would have an adverse effect on the number of tourists visiting NSW.

The following is the report provided by the consultant, Mr Alan Shiell. In relation to this report, the following comments are made:

- The Taskforce has received advice from the industry representatives that more recent figures (1994/95) relating to employment in the hospitality industry are now available. As a result, the Taskforce considers that the figures quoted in Table 1 in this report underestimate the numbers currently employed in the different sectors of the industry. Figures provided to the Taskforce by the hospitality industry estimate there are 65,000 people in paid employment in registered clubs in NSW and the restaurant and cafe industry employs approximately 53,000 people. Therefore estimates of employees at risk from hazardous levels of ETS are likely to be understated.

- The Taskforce is informed that the current cost for the Quit Campaign's public education program is $600,000. Therefore, the costs estimated in Table 6 for public education campaigns and training for options 3, 4 and 5 would include the existing allocation of $600,000 per year and therefore an additional $400,000 per year is required, rather than additional $1,000,000 per year for 2 years.

- Therefore the total undiscounted costs over a three year period are as follows

Options	Total Costs (undiscounted)
Option 2	$ 812 380
Option 3	$2 429 520
Option 4	$3 238 380
Option 5	$2 596 200

Source: Adapted from Table 6 Shiell Report

Two omissions from tables 6 and 7 need to be noted. The first is the effect of intervention on litigation costs. Each of the active interventions (that is options 2 to 5) is expected to reduce the costs associated with litigation below that expected under option 1 but for reasons discussed in the report above it is not possible to specify the impact that each would have. It is expected that litigation costs to be minimised under options 3 and 5 since these options effectively eliminate new exposure leaving only cases of past exposure to be dealt with.

The second omission is the uncertain effect on industry revenues. It is unlikely that there would be a significant effect on restaurants and cafes, it is more difficult to predict the effect on clubs and hotels based on the evidence available.

To some extent the effects of these two uncertain components of future costs work against each other.

The Taskforce is also informed that Non Government organisations such as the NSW Cancer Council and the National Heart Foundation have already made and will continue to make investment in public education strategies and strategies targeting the hospitality industry in relation to passive smoking issues.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Indicative evaluation of the costs and effects of proposals to reduce the harm associated with environmental tobacco smoke in the hospitality industry

A report to the NSW Passive Smoking Taskforce

by

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NSW 2006

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Summary

An estimate of the costs and effects of options to reduce or eliminate exposure to environmental tobacco smoke is presented. The estimates are incomplete but some indication of the relative cost-effectiveness of five options and some insight into the remaining areas of uncertainty are provided. The options considered were (1) to maintain the status quo; (2) to strengthen the existing occupational health and safety legislation; (3) to introduce a complete smoking ban in all indoor areas where food and beverages are served; (4) to ban smoking in all indoor areas where food and beverages are served except those with adequate ventilation meeting required standards; (5) to introduce a complete smoking ban in all indoor areas where food and beverages are served and enhance existing occupational health and safety legislation.

The results suggest that the more effective options, where effectiveness is defined only in terms of reduction in exposure to ETS, are also the more expensive options. Thus greater health benefit only comes at greater cost. The one exception to this is option 4 which is both more expensive and less effective than either option 3 or option 5. However this option offers other benefits in that it allows tobacco users to continue to smoke while they eat and drink whilst also providing smoke-free areas. Most of the additional costs of option 4 would be borne privately by venue operators who could decide on commercial grounds whether or not the investment in ventilation was worthwhile. However, ventilation is not 100% effective in removing the hazards associated with ETS and therefore staff members will continue to be exposed to the risk of ill-health. Option 4 could therefore be rejected on public health grounds though not necessarily economic ones.

The merits of the remaining options depend to a large extent on the effectiveness of enhanced OHS legislation. If it is believed that this will break the current stalemate which has prevented existing OHS legislation from working as well in the hospitality industry as it has in other workplaces then option 2 offers the least cost way of promoting the health of staff and patrons. If the effectiveness of enhanced OHS legislation alone is doubted then public health legislation (options 3 and 5) has been to be work albeit at higher cost.

The introduction of public health legislation to ban smoking in public places will cost an

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additional $3,507,670 over three years and offer protection from the hazards of ETS to at least 30,000 people over the same time period (70% of the estimated number of staff members at risk - patrons excluded). Part of this cost will be offset by savings in health care costs but these benefits are unlikely to be realised for some time and their impact is reduced with discounting. Protection would be extended still further if public health legislation is augmented by enhanced OHS legislation (option 5) but only at an additional cost of $166,680 over three years.

In summary, on the basis of the information and assumptions presented here, there is no option which is clearly better than the others. It is not possible therefore to draw a conclusion from the economic evaluation alone. The fact that higher levels of impact come only at higher costs means that the Taskforce cannot avoid making a judgement about the value of the health gains to be achieved. The evaluation has made explicit some of the costs and consequences of the options being considered. Whilst not making the Taskforce's job any easier, this does open to scrutiny any recommendation that the Taskforce might eventually make.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Introduction

This report presents an indication of the likely costs and effects of five alternative methods of reducing the harm associated with passive smoking in the hospitality industry. The issue of whether or not intervention *per se* is worthwhile has not been considered. As a starting point, it is therefore assumed that the health benefits to be gained from restricting smoking in venues in the hospitality industry warrant intervention in some form or other. The question is how should this be best achieved. The evaluation is therefore an indicative estimate of the cost-effectiveness of intervention, not its cost-benefit.

A full evaluation of the costs and effects has not been attempted given resource and time constraints. The major omission in this regard is the health impact of the options. Instead, the aim has been to identify the range of costs and effects, to provide the taskforce with estimates of their likely magnitude where such information is readily available and to highlight any areas of uncertainty which remain through lack of information. This may be sufficient to recommend one option over the others if the unquantified costs and effects all point in the same direction, ie if one option is more effective and no more costly or more costly and no more effective even when one takes into account the direction and likely size of any omitted costs or outcomes. A more detailed examination of the areas of uncertainty or unknown cost-benefit would be necessary if the unquantified costs and effects of different options move in opposite directions or if one option appears to be both better and more expensive than the others.

Structure of the Hospitality Industry in NSW

Details of the structure of the hospitality industry in NSW for 1991-1992 are shown in table 1 (ABS, 1994). More than one-third (37%) of businesses in the hospitality industry operated in NSW. Similarly, 39% of those employed in the industry work in NSW. Gross profit margins in the industry in Australia as a whole (NSW figures not available) averaged 1.7% in pubs, bars and taverns; 3.2% in cafes and restaurants and 4.8% in licensed clubs.

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Table 1 The Structure of the Hospitality Industry in NSW (1991-92)[1]

SECTOR OF INDUSTRY	Number of businesses	Total employment
Pubs, bars and taverns	1,387	24,843
Cafes and restaurants	3,349	40,198
Licensed clubs	1,544	40,677
TOTAL	6,280	105,718

(1) ABS Hospitality Industries: Australia 1991-92. Catalogue no 8674.0

Options for reducing the harm associated with ETS in the hospitality industry

The task force identified five options for evaluation:

OPTION 1: Maintain the status quo

OPTION 2: Strengthen existing occupational health and safety legislation

OPTION 3: Smoking prohibited in all indoor areas where food and beverages are served

OPTION 4: Smoking prohibited in indoor areas except designated areas, ie those areas with separate ventilation extraction systems meeting certain specifications

OPTION 5: Smoking prohibited in all indoor areas where food and beverages are served combined with enhancement of current occupational health and safety legislation and regulations

Likely effectiveness of the options

The status quo, as enshrined in existing OHS legislation and involving voluntary action by proprietors and patrons, provides a baseline against which each of the other interventions may be evaluated. This option is essentially a 'do nothing different' rather than a 'do-nothing' approach. As there is no intervention there are no direct costs to consider. However, the option is not costless. Neither is it stable or unchanging. Future

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costs and effects depend critically on the extent to which the link between passive smoking and ill-health becomes accepted in law. Based on best and worst case scenarios Workcover estimate that costs arising from litigation over passive smoking to industry as a whole in NSW could range from $4 million to $80 million (Rod McGuinness, personal communication). Less than 1% of the employed labour force in NSW works in the hospitality industry but since 80% or so of other workplaces are now smoke-free the share of the total cost falling upon the hospitality industry will be considerably greater than that suggested by its share of employment. Unfortunately, it is not possible to estimate the proportion of litigation costs that will fall on the hospitality industry without knowing more about the original Workcover estimates. The share would be affected by, among other things, the proportion of the costs due to litigation rather than health care or lost production and the assumptions that were made about the growth in the number of smoke-free workplaces.

The effectiveness of the interventions being considered depends on the degree of compliance achieved. Self-regulation (the status quo) has proved markedly more successful in general workplaces than in the hospitality industry. The argument that this reflects customer-preference is unsustainable given the numerous surveys showing positive support for smoke-free areas, particularly in restaurants (McAllister, 1995). The perceived failure of self-regulation is more likely the result of the competitive pressures acting upon venue operators. No matter what the evidence venue operators appear to believe that a smoking ban will lead to loss of custom particularly if they alone introduce restrictions (Sciacca, 1996). Thus, it would seem that the risk of litigation under existing occupational health and safety legislation and liability for workers' compensation is judged the lesser of two evils when weighed up against the potential loss of custom that might arise from taking a lead on passive smoking (Semmonds et al, 1995; RCA, 1996). This position will, of course, change should any action be taken against operators.

The effectiveness of option 2, which involves strengthening existing OHS legislation as it applies to the hospitality industry, therefore depends on the impact its implementation has on industry perceptions of the likelihood of legal action being successfully taken. If successful action under enhanced OHS legislation seemed highly probable such that the expected cost of litigation if smoking was allowed exceeded the expected loss of income if smoking was banned unilaterally, then operators could be reassured that anyone who chose to initiate smoking restrictions would not be put at a competitive

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disadvantage. Ultimately, the threat of litigation would lead venues either to ban smoking or to provide ventilation. The effectiveness of this option can therefore ultimately be no greater than either of these other two.

The barrier to change imposed by the potential loss associated with being the first operator to introduce smoking restrictions is an argument in favour of public health legislation under option 3 (Semmonds et al, 1995). Compliance with total bans on smoking in public places varies and is highest where the introduction of legislation is supported by both a general information campaign to increase public awareness and staff training in how to deal with the smoking behaviour of patrons (Norstrom and DeStefano, 1995; Kagan and Skolnick, 1993). If knowledge and acceptability of the restrictions is high then public pressure will ensure compliance and formal enforcement can be low-key (Kagan and Skolnick, 1993).

Option 4 will be the hardest to enforce as any infringement of the ventilation standard will not be readily visible to customers. Public pressure on operators to comply with the legislation is therefore reduced. Ventilation may be installed to obtain exemptions but then not utilised to save costs. The success of this option will also depend on the extent to which smokers and non-smokers are separated from each other and on the effectiveness of the ventilation system. Simple division of a common dining space into smoking and non-smoking areas reduces but does not eliminate exposure of non-smokers to ETS (Lambert et al, 1993). Similarly, current ventilation standards (AS 1668.2) reduce the level of ETS but do not eliminate the risks entirely (Broadbent and Wesley, 1996). The provision of separate areas in which smoking is allowed will offer protection to patrons but staff who must work in the areas will continue to be exposed.

Option 5 combines the public health legislation approach of option 3 with the strengthening of occupational health measures as in option 2. This option clarifies the legal responsibilities of hospitality industry operators bringing them in line with other workplaces and this may increase compliance. The dual approach also extends coverage of the public health regulations to public places that are not workplaces but where food is served and to workplaces within the hospitality industry which are run by sole traders with no employees. The reach of the measure is therefore increased.

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Identification of likely costs and consequences

Five main parties are each likely to be affected by proposals to reduce the harm associated with ETS. The parties are:

- the NSW Department of Health and other public sector agencies
- the hospitality industry (hotels, clubs and restaurants)
- staff working in the hospitality industry
- tobacco smoking patrons
- non-smoking patrons

Other parties such as the tourist industry may also be affected by restrictions on smoking in public places.

Table 2 shows the likely categories of costs and effects as they might be expected to impact on each of the groups identified above. Costs are broadly associated with the initial implementation of the chosen option followed by subsequent monitoring of compliance.

Some of the costs and effects identified in table 2 represent transfers from one group of society to another. They do not constitute a net cost or benefit to society overall. Care needs to be taken in such cases to avoid double counting. For example, worker's compensation payments to employees affected by passive smoking represent a cost to the industry and an income to the employee concerned. These cancel each other out save for the administrative costs involved. The real effect in this case is the physical harm that has been done to the employee for which the payment may or may not represent adequate compensation. Including both the health effects and the compensation payments in the evaluation would amount to double counting.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Table 2 **Range of likely costs and effects of measures to reduce ETS exposure in the hospitality industry**

NSW HEALTH DEPARTMENT & PUBLIC AGENCIES	HOSPITALITY INDUSTRY	INDUSTRY EMPLOYEES	SMOKING PATRONS	NON-SMOKING PATRONS	OTHER PARTIES
Enforcement	Change in custom - short term - long term	Health gains	Health gains	Health gains	Tourist industry - change in income
Inspections	Signage, cleaning	Welfare (non-health) gain	Welfare (non-health) loss	Welfare (non-health) gain	
Training / Education	Ventilation - installation - maintenance - operation Capital works Inspection costs Legal liability - worker's compensation - OHS				

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Resource requirements of the policy options

Education and information campaigns to advertise new restrictions

The effectiveness of the options is partially dependent on there being an effective education and training campaign to ensure compliance (Kagan and Skolnick, 1993). Responsibility for community education and training for both hospitality industry workers and workers in the public health system would lie mainly with the QUIT campaign. A precise estimate of the cost is not possible at this stage though past QUIT campaigns have cost in the order of $600,000 per annum (J Urquhart, personal communication). This figure may be appropriate for options 2 and 4 but the more extensive nature of the public health legislative options (options 3 and 5 involving a complete ban) suggests that it might require a larger investment in community education. The Health Department estimate that campaign costs for options 3 and 5 will be in the order of $1 million per year for each of two years.

Included in this figure is the cost of developing the teaching materials needed to train staff in the hospitality industry. That is, QUIT would incur the cost of development even though responsibility for training would rest with the industry. Once the materials had been developed they could be integrated into the usual training programmes offered by the industry at minimal marginal cost.

Non-Government agencies such as the National Heart Foundation and the NSW Cancer Council would also play an important role in public education. The involvement of such groups is only likely to affect the relative costs of the options being considered if the resource requirements of the campaigns that each introduced differed substantially across the three options. In the absence of information to the contrary it is assumed that the unit cost of campaigns initiated by such bodies would not depend on the choice of option.

Public sector costs of enforcing regulations

The blanket nature of the public health regulations introduced in options 3 and 5 and its transparency make monitoring of compliance relatively easy. Effectively, each patron becomes a monitor. Once a 'climate of compliance' had been created, formal monitoring could be incorporated into existing complaints system and food and environmental health inspections at little or no additional cost to the public purse. Even so, advice from the Health Department suggests that a three year investment

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would be needed in order to generate the required climate of compliance. This would involve an additional Environmental Health Officer in each Public Health Unit to facilitate local action by Area Health Services. One Policy Officer would also be required centrally to coordinate and support these local initiatives.

Public complaints would also be relied upon to alert the Department of Health to venues where the regulations were not being followed. The mechanism for public complaint already exists in the use of telephone 'hot-lines' which members of the public can call to register their complaints or seek for information about the regulations. On the basis of discussions with staff in the Department of Health, this would probably require one full-time project officer at grade 5/6 for a period of up to twelve months after the introduction of the new regulations (D Crowley, personal communication).

Option 4 would also require a system for administering applications for exemption to be established as well as a system of inspection to ensure that ventilation equipment of a sufficient standard had been installed and was being used as appropriate. The costs of administration and inspection could be passed on to the hospitality industry as a user-charge.

Responsibility for implementing option 2 and, by extension, the OHS part of option 5 would probably fall to Workcover. Past experience suggests that this would require two additional inspectors with full-time administrative assistance plus one day per week input at senior executive level for supervision and management (P Harley, personal communication).

Other costs associated with the options

Effects on income of hospitality industry

The available evidence on the effects of smoking regulations in restaurants and bars is reviewed in appendix 1. In general, this evidence suggests that the introduction of smoking restrictions in restaurants has had no net negative effect on custom. Any reduction in custom from smokers appears short-term and is eventually off-set by a corresponding increase in patronage from non-smokers and/or the return of smoking patrons. Fears expressed by establishment operators that the introduction of smoking

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restrictions would lead to substantial reductions in custom have not been realised (Sciacca, 1996).

However, the studies from which this conclusion is drawn are all from the USA. Whether or not the same results would be seen in Australia remains an open question. The experience in the ACT, where partial restrictions on smoking in restaurants were introduced in December 1994, sheds some light on the matter. Seasonally adjusted sales data showing monthly retail turnover is shown in table 3.

The series combines turnover data for both the hospitality industry and some services (namely video outlets and hairdressing salons). It is not possible to separate out the different components, however, as over 85% of the turnover figure is generated by the hospitality industry any distortion should be slight. The data suggest a drop in sales activity in January 1995, the month after the introduction of smoking restrictions, but it is impossible to say whether this was a result of the regulations or some other factor such as a post-Christmas downturn. The fall was, in any case, quickly reversed and retail sales activity in the ACT was generally more buoyant in 1995 than in the rest of Australia (ABS, Retail Trade Survey 8501.0).

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Table 3 **Monthly Retail Turnover in ACT - Hospitality and Services - seasonally adjusted figures ($ million)**

MONTH IN WHICH RETAIL SERIES WAS COMPILED

	Jan 95	Apr 95	Jul 95	Oct 95	Jan 96	Apr 96	Jul 96
Nov 93	25.4						
Dec 93	28.7						
Jan 94	29.0						
Feb 94	28.5	28.5					
Mar 94	31.3	31.3					
Apr 94	30.0	30.0					
May 94	29.0	29.0	29,4				
Jun 94	28.5	28.5	28.6				
Jul 94	30.0	30.0	29.6				
Aug 94	28.8	28.8	28.8	28.8			
Sep 94	28.5	28.5	28.2	28.2			
Oct 94	25.8	25.8	26.3	26.3			
Nov 94	27.6	27.6	28.0	28.0	28.0		
Dec 94	**27.7**	**27.7**	**28.6**	**28.5**	**28.5**		
Jan 95	**25.7**	**25.7**	**25.7**	**25.9**	**25.9**		
Feb 95		**31.3**	**31.0**	**31.0**	**31.0**	**31.0**	
Mar 95		31.4	30.8	30.7	30.7	30.7	
Apr 95		30.7	29.6	29.7	29.7	29.7	
May 95			30.2	30.2	30.2	30.2	29.7
Jun 95			28.8	28.8	28.8	28.8	28.9
Jul 95			31.1	31.2	31.2	31.2	30.4
Aug 95				28.3	28.3	28.3	28.4
Sep 95				28.3	28.3	28.3	28.5
Oct 95				28.1	28.1	28.1	28.6
Nov 95					27.3	27.3	27.7
Dec 95					27.9	27.9	27.9
Jan 96					28.8	28.8	29.1
Feb 96						29.8	29.4
Mar 96						29.2	28.8
Apr 96						29.1	28.8
May 96							29.4
Jun 96							29.1
Jul 96							31.1

Source: ABS Retail Trade (monthly series). ABS catalogue number 8501.0

The effect on patronage of hotels and bars is more difficult to assess. The little international evidence that is available suggests that bars would not be adversely affected (Taylor Consulting, 1993). However, this study also reported that the

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regulations were only enforced selectively.

There is no equivalent evidence from Australia on the effect of smoking restrictions on bars and hotels. The survey of community intentions by Schofield and Edwards suggests that there might be a small net-fall in patronage (Schofield and Edwards, 1995).The hotel market in Australia is segmented with different types of hotels serving different client groups and the effect of smoking restrictions is likely to be felt harder by hotels serving populations with less income and lower levels of secondary education (Schofield and Edwards, 1995). Previous estimates based on behavioural intention have, however, provided poor indication of the actual impact of smoking regulations on income.

Costs of installing and maintaining ventilation extraction systems

The capital costs associated with meeting existing air-quality standards which offer incomplete health protection (AS 1668.2) are in the order of $400 per patron or $215 if the large casino development is excluded (see table 4 for details) (Broadbent and Wesley, 1996).

Table 4 Capital cost to install ventilation capable of meeting AS 1668.2

TYPE OF VENUE	Capacity	Capital cost	Cost / 'place'
Restaurant	24 people	$ 3,000	$125
Hotel	94 people	$ 20,000	$213
Hotel	290 people	$ 70,000	$241
Club (Casino)	600 people	$325,000	$542
Restaurant	127 people	$ 22,000	$173
TOTAL	**1135 people**	**$440,000**	**$388**

The capital cost to install equipment of the capacity needed to maintain a level of air-quality which minimises the risks of adverse health effects of ETS in an average 70 seat restaurant has been estimated to lie between $400,000 and $525,000 which is equivalent to $5,714 - $7,500 per place (Broadbent and Wesley, 1996).

Annual recurrent costs associated with the maintenance and operation of ventilation equipment will depend critically on local circumstances. However, Broadbent and

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Wesley (1996) suggest that recurrent costs of around one-half the initial capital investment would not be unusual.

The total costs of ventilation would depend on the number of operators who would apply for exemptions under option 4. In the ACT, where the legislation only requires AS 1668.2 to be achieved, 10 restaurants had ventilation systems of the required standard installed before the regulations were introduced and fewer than 10 restaurants applied for exemptions following the introduction of the regulations. None of these went on to install the ventilation equipment. This suggests that few operators consider the expense of installing and running a ventilation system to be worthwhile even at the relatively lower costs required to achieve AS 1668.2.

If one uses the ABS estimates of the numbers of cafes and restaurants in the ACT, then the number applying for exemption represents 5% of the total number of cafes and restaurants in the territory. Assuming that the same proportion of venues would apply for exemption in NSW suggests that around 170 cafes and restaurants would be expected to apply in the first year if current air-quality standards were imposed. If this figure is extrapolated to all hospitality industry venues then around 315 operators would apply for exemptions. Considerably fewer operators are likely to apply if the higher air-quality standard is imposed instead. Indeed, it is likely that no operator would consider the costs worthwhile.

Other costs to industry

Cleaning costs may also be reduced following the introduction of smoking regulations. Unlike other workplaces, however, the savings are unlikely to be substantial (Jackson and Holle, 1985).

A potentially more important cost to the industry is that associated with litigation and workers' compensation. Workcover estimate that they carry out 15 or so inspections per month in relation to the Occupational Health and Safety legislation in response to complaints from employees. One third of these involve the hospitality industry (P Harley, personal communication). With over 6,000 businesses in NSW, the chances of an inspection are therefore low (5 in 6,000). The chances of court action being taken against any individual owner under the legislation are lower still as most breaches are resolved through negotiation. Although the costs associated with a successful action against any one operator can be substantial the risks of incurring

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such costs appear negligible if past experience is used as a guide. Information from Workcover suggests that there have been less than 12 cases over the past decade involving a total cost of less than $500,000. As one case was responsible for about one-half of this cost the average cost for most cases was nearer $20,000 (Rod McGuinness, personal communication). As suggested above, these costs are expected to rise in the future though the burden falling upon the hospitality industry is unclear.

Health and non-health outcomes

Health effects on staff working in hospitality industry

The health benefits of efforts to reduce exposure to ETS depend on the degree of compliance, the effect this has on exposure, the effect that change in exposure has on risk and finally the effect that change in risk has on change in health state.

There are no Australian studies reporting the levels of exposure to ETS of staff in the hospitality industry and therefore no information upon which to base estimates of the health impact of the options being considered here. A published review of studies carried out in the USA suggested that levels of ETS in restaurants were 1.6 to 2.0 times higher than in office workplaces and 1.5 times higher than homes in which at least one person smokes. ETS levels in bars and clubs were 3.9 to 6.1 times as high as workplaces and 4.4 to 4.5 times higher than homes (Siegel 1993). Epidemiological evidence from six studies in the USA indicates that food-service workers may have a 50% increase in the risk of lung-cancer after controlling for age and smoking status though not all of this could be attributable to ETS (Siegel, 1993).

A crude estimate of the numbers of staff at risk of exposure to ETS is presented in table 5. The number at risk depends on the proportion of staff who are smokers; the proportion of staff already working in smoke-free venues and the proportion of staff who work in areas in venues where smoking is already banned (such as kitchens and areas where food is served). The results, based on the assumptions outlined in the footnotes to the table, suggest that between 44,490 and 51,340 staff members are exposed to hazardous levels of ETS each year.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Table 5 Estimated numbers of employees at risk from ETS

	Hotels, bars and taverns	Cafes and restaurants	Licensed clubs
Total employment	20,973 [1]	44,465 [2]	41,345 [1]
% non-smokers among staff[3]	75%	75%	75%
% venues not smoke-free	80 - 100%	80% [4]	80-100%
% staff in 'front of house'	85% [1]	60% [5]	71% [1
% staff at risk [6]	51 - 64%	36%	43%-53%
Number of staff at risk	10,700 - 13,420	16,010	17,780 - 21,910

NOTES

(1) ABS 1994-95 Clubs, Pubs, Taverns and Bars, Cat No 8687.0
(2) ABS 1991-92 Retail Census
(3) Based on population estimate of smoking prevalence of 25%
(4) Schofield et al (1993)
(5) Personal communication Restaurant and Catering Association of NSW
(6) Based on best and worst case percentages

The basis for this estimate is total employment numbers taken from past ABS surveys of the hospitality industry. The number of people employed in the industry is substantially lower according to the ABS estimates than figures provided by the respective trade groups. If the trades organisations' figures were used instead the number of staff at risk would increase.

Health effect on non-smoking patrons

There are no published studies reporting levels of exposure to ETS and consequent risk of ill-health among non-smoking patrons of restaurants, clubs or hotels (it is assumed that the direct health risks associated with tobacco use by smokers drowns any risks associated with ETS). Neither is it possible to estimate the numbers of patrons at risk in the absence of data on the frequency with which individuals patronise hospitality industry venues.

Measures which protect staff will also protect patrons hence the absolute effectiveness of each of the options is understated by omitting patron effects and the

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absolute cost-effectiveness is overstated (options appear more expensive per unit of outcome achieved than would otherwise be the case). The relative cost-effectiveness of the options will also be affected if the health effects of patrons were included in the evaluation though probably not substantially given that patrons are likely to have much lower levels of exposure than employees. As with staff, only option 3 fully protects patrons from the risks of ETS exposure. Option 4, however, is potentially as effective as option 1 at reducing the risk to non-smoking patrons since it provides them the opportunity to avoid eating or drinking in a smoke-filled atmosphere. The impact of option 2 depends upon the time frame over which venues comply with the enhanced legislation. By definition this option can be no more effective than option 3 or 5.

Welfare effects on staff and patrons (smoking and non-smoking)

Welfare is used here in its economic sense to refer to the satisfaction that some patrons currently obtain from the freedom to smoke in public venues and that other patrons (smokers and non-smokers alike) would obtain were they given the freedom to eat and drink in a non-smoking environment. The term encapsulates the non-health effects of smoking behaviour, both beneficial to those who prefer to smoke and non-beneficial to those who prefer not to. Restrictions on smoking in public places would be expected to diminish the (non-health) welfare of the former group whilst enhancing the welfare of the latter.

The net effect of these changes among patrons is reflected partially in the income received by the hospitality industry since this indicates what the marginal consumer is willing to pay to consume food and beverages in a smoke versus a smoke free environment. The marginal consumer is the one most responsive to changes in the smoking regulations. The evidence from the USA discussed above indicates that there is no long term effect on restaurant revenues. Thus, at the margin, the welfare gains which would accrue to those who would prefer to eat in a smoke-free environment after the introduction of smoking restrictions are at least equal to the welfare losses of those who would prefer to be allowed to smoke tobacco.

But, in addition to those marginal customers whose behaviour would change as a result of restrictions being introduced there are also a number of intra-marginal patrons, both smoking and non-smoking alike, whose use of restaurants, clubs and hotels would not change but whose welfare or satisfaction derived from the

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experience would still be affected. If non-smokers have the same demand characteristics of smokers (that is they are equally responsive to changes in the price of meals and beverages) then, by virtue of their greater number, the welfare gains of intra-marginal non-smoking patrons will exceed any welfare loss incurred by intra-marginal smokers. The net effect therefore is an increase in customer satisfaction with no effect on industry revenues.

This conclusion would appear to be borne out, at least in the case of restaurants, by surveys which indicate majority support for restrictions on smoking even among current smokers (Schofield, 1995). For example, in a national survey of 3500 people in Australia, McAllister (1995) found that 71% of the sample supported the banning of smoking in restaurants while only 14% were opposed to such restrictions. Support for smoking bans in pubs and clubs was also positive but was less strong (42% supporting a ban in pubs and clubs with 36% opposed to the restrictions).

Impact on the tourist industry

The perception that the introduction of smoking restrictions in hotels, clubs and restaurants in NSW would have adverse effects on the number of tourists visiting the state is not borne out by what little evidence is available. In the USA, the study by Glantz and Smith (1993) shows no drop in restaurant revenues in those areas largely dependent on the tourist trade. Similarly, a study of convention organisers in San Diego found that 38 of the 40 organisations surveyed (representing 174,840 or 97% of all delegates) would not be deterred from coming back to San Diego following the introduction of a smoking ban (TFSFSD 1992).

In Australia, the Bureau of Tourism Research (BTR, 1995) regularly surveys international visitors and documents their reasons for visiting Australia. The results however are not sufficiently detailed to shed light on the question of whether smoking regulations might deter visitors. The results of initiatives by Queensland Health and South Coast Regional Health Authority to reduce passive smoking in tourist facilities on the Gold Coast would suggest that fears of a downturn in tourist activity following restrictions on smoking are unfounded. Restaurants on the Gold Coast appear to be more likely to provide smoke-free dining areas than restaurants in NSW (Tilse, 1993; Schofield et al, 1993). Surveys of Japanese visitors to the Gold Coast and local patrons show that both groups have equal preferences for restaurants with smoke-free areas with 88% of those surveyed in both groups saying they would prefer

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restaurants to be either totally smoke-free or to offer a non-smoking area (Morrison and Sutton, 1994).

Valuation of costs

An estimate of the relative costs of each of the intervention-options based on the resource-effects identified above is presented in table 6. Costs are estimated for a 3 year time frame only as the resources required by each of the options beyond this period is uncertain.

The establishment of a telephone hot-line to take public complaints is expected to require one full-time staff member at grade 5/6 for up to one year. Total cost for this component is therefore $45,520. Implementation of the public health legislation would involve 14 additional Environmental Health Officers plus one central co-ordinator over three years. Information on all public service salary costs was obtained from the Staffing Office, NSW Health Department.

The cost of the education and training campaign for each option was based on information provided by Julie Urquhart of the NSW QUIT campaign. Costs associated with the educational activities of non-Government agencies such as the National Heart Foundation and the Cancer Council of NSW have not been shown as they are likely to be common across options.

Implementation costs for public health legislation are based on the assumption that each Public Health Unit would be provided by a full-time Environmental Health Officer for three years. Implementation costs of the OHS options are based on the estimated increase in inspection staff discussed above. This includes two full-time inspectors employed as Senior Policy Analysts on grade 9/10 (annual cost $58,430), one-fifth of a senior executive salary ($20,000) plus full-time administrative support ($30,000). The total cost is therefore $166,860 in the first year.

The cost of achieving the high standard of air quality needed to protect health under option 4 appears prohibitive (Broadbent and Wesley, 1996). In this case, option 4 would degenerate into option 3 - effectively a ban on smoking as venue operators refused to apply for exemptions. The costs associated with option 4 in table 6

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therefore relate to the achievement of current amenity standards of air quality (AS 1668.2). The estimates assume that 5% of venues (n=314) will apply for exemptions based on existing or newly installed ventilation systems. The initial inspection and subsequent monitoring of ventilation systems has been assumed to require 5 hours staff time per venue per year. This has been costed at a professional rate of $120 per hour (P Harley, personal communication).

No effect is anticipated on the tourist industry except perhaps greater satisfaction among the 80% of patrons (both foreign and local alike) who would prefer to dine in a smoke-free environment.

Savings in cleaning costs and costs associated with signage etc. are assumed to be negligible. The effect on industry income under option 1 is uncertain and this uncertainty is also reflected in option 3 if venues choose to introduce smoking bans.

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Table 6 Costs over time for each of the intervention options

OPTION 2: strengthen OHS legislation	**Year 1**	**Year 2**	**Year 3**	**Total (undiscounted)**
Telephone hotline	45 520			45 520
QUIT education and training	600 000			600 000
Workcover implementation	166 860			166 680
Monitoring				
TOTAL	**812 380**			**812 380**

OPTION 3: Public health legislation	**Year 1**	**Year 2**	**Year 3**	**Total (undiscounted)**
Telephone hotline	45 520			45 520
QUIT education and training	1 000 000	1 000 000		2 000 000
Public health implementation	528 000	528 000	528 000	1 584 000
Monitoring				
TOTAL	**1 573 520**	**1 528 000**	**528 000**	**3 629 520**

OPTION 4: Public health legislation with exemptions	**Year 1**	**Year 2**	**Year 3**	**Total (undiscounted)**
Telephone hotline	45 520			45 520
QUIT education and training	1 000 000	1 000 000		2 000 000
Public health implementation	528 000	528 000	528 000	1 584 000
Monitoring (314 venues)	188 400	188 400	188 400	565 200
Ventilation (314 venues)	121 830	60 915	60 915	243 660
TOTAL	**1 883 750**	**1 777 315**	**777 315**	**4 438 380**

OPTION 5: Dual - OHS and public health legislation	**Year 1**	**Year 2**	**Year 3**	**Total (undiscounted)**
Telephone hotline	45 520			45 520
QUIT education and training	1 000 000	1 000 000		2 000 000
Public Health implementation	528 000	528 000	528 000	1 584 000
Workcover implementation	166 680			166 680
Monitoring				
TOTAL	**1 740 200**	**1 528 000**	**528 000**	**3 796 200**

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As the time over which costs are incurred varies among the options it is necessary to discount future costs to a present value before comparisons can be made. Table 7 reports the discounted total costs. Marginal costs are also shown in this table, that is the change in total cost as one moves from an option of lesser effectiveness to a more expensive but also more effective option.

Table 7 Discounted Total and Marginal Costs

	Total Cost (discounted)[1]	Marginal Cost
OPTION 1: Status quo[2]	No intervention	
OPTION 2: Strengthen OHS legislation[2]	$ 812 380	$ 812 380 - over option 1
OPTION 3: Public health legislation	$ 3 507 670	$2 695 290 - over option 2
OPTION 4: Public health ban with exemptions	$ 4 281 480	*Option dominated (see text)*
OPTION 5: Dual PH and OHS approach	$ 3 674 350	$ 166 680 - over option 3

(1) Flow of costs over time discounted at 5%
(2) Excludes litigation costs

Two omissions from tables 6 and 7 need to be noted. The first is the effect of intervention on litigation costs. Each of the active interventions (that is options 2 to 5) is expected to reduce the costs associated with litigation below that expected under option 1 but for reasons discussed in the text above it is not possible to specify the impact that each would have. One would expect litigation costs to be minimised under options 3 and 5 since these options effectively eliminate new exposure leaving only cases of past exposure to be dealt with. The second omission is the uncertain effect on industry revenues also discussed above. To reiterate, the effect on restaurants and cafes is unlikely to be substantial. For some hotels and clubs, however, the effect may be important. The impact will be greatest under options 3 and 5, will be smaller under option 4 if venue operators decide to take advantage of exemptions and will be least of all under option 2 if venue operators decide to continue to allow smoking on the premises.

To some extent therefore the effects of these two uncertain components of future costs work against each other.

Cost effectiveness

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With the exception of option 4, no single option dominates the others in being both more effective and less expensive. In terms of its health impact, option 4 is dominated by options 3 and 5 but it offers other benefits that might be valued. The extra cost is explained mainly by private costs which the industry may choose to incur voluntarily in order to continue to allow smoking on the premises. It is not therefore possible to rule this option out on economic grounds. It may, however, be ruled out for public health reasons since the ventilation standards on which this cost-estimate is based provide incomplete health protection. Some of the 'cost' of this option is therefore borne by staff members who remain at risk of ETS-related ill health.

While it is not possible to estimate the health gains that might accrue to staff and patrons it is possible to express the relative effectiveness of each of the policy options according to the impact that each is expected to have on reducing the number of staff at risk of exposure. The cost-effectiveness of the options may then be expressed in terms of the cost per person-year of exposure avoided.

The lower-bound estimate of staff at risk of exposure to ETS is 44 490. This is equivalent to 133 470 person-years of exposure over the 3 years for which costs were estimated or 127 215 person-years of exposure if discounted at 5%. This represents the maximum reduction that could be achieved in staff exposure to ETS if compliance with a given intervention was complete. To estimate the actual cost-effectiveness of each of the options it is therefore necessary to make further assumptions about the levels of compliance that each is likely to achieve. For example, if an option is expected to increase the proportion of smoke-free venues by 10% then one might expect a proportional reduction in the number of person-years of exposure to ETS (ie 10% of 127 215 = 12 722).

The marginal cost per person-year of exposure avoided based on varied assumptions about the difference in the proportion of smoke-free venues is shown in tables 8 and 9. Table 8, for example, presents the results for options 2 and 3. Option 2 is expected to cost and extra $812 380 over and above option 1. If the introduction of enhanced OHS legislation is believed to lead to an absolute increase in the proportion of venues smoke-free of 50% (ie from 20% to 70% of all venues in the hospitality industry) then the number of person-years of exposure will be reduced by 63 610 over three years at a marginal cost of $12.80 per person-year. Similarly, if introducing public health legislation (option 3) was expected to lead to an improvement in the proportion of

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smoke free venues from the current 20% to 90%, then the additional cost, over and above option 1, would be $3 570 670. The number of person-years of exposure would be reduced by 89 050 over three years at a marginal cost of $55.20 per person-year of exposure avoided.

Table 8 Marginal Cost-Effectiveness of Options 2 and 3

Change in proportion of smoke-free venues	Person-years of exposure avoided	Cost per Person-Year of Exposure Avoided		
		Option 2 v Option 1	Option 3 v Option 1	Option 3 v Option 2
100%	127 215	$ 6.40	$ 27 60	$ 21.20
90%	114 495	$ 7.10	$ 30.60	$ 23.50
80%	101 770	$ 8.00	$ 34.50	$ 26.50
70%	89 050	$ 9.10	$ 39.40	$ 30.30
60%	76 330	$ 10.60	$ 46.00	$ 35.30
50%	63 610	$ 12.80	$ 55.20	$ 42.40
40%	50 885	$ 16.00	$ 68.90	$ 53.00
30%	38 165	$ 21.30	$ 91.90	$ 70.60
20%	25 445	$ 31.90	$137.90	$105.90
10%	12 770	$ 63.90	$275.70	$211.90

As the impact of option 5 over and above option 3 is likely to be less dramatic, its marginal cost-effectiveness is shown in table 9 for a smaller range of changes in effect. Thus, if it was believed that the proportion of smoke free venues would increase from (say) 90% to 96% if the public health legislation was augmented by an enhanced OHS approach then the additional cost would be $166 680 and the number of person-years of exposure would fall by a further 7 630 at a marginal cost of $21.80 per person-year.

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Table 9 Marginal cost-effectiveness of option 5 over option 3

Change in proportion of smoke-free venues	Reduction in person-years of exposure	Cost per person-year of exposure avoided Option 5 v option 3
10%	12 770	$ 13.10
8%	10 175	$ 16.40
6%	7 630	$ 21.80
4%	5 090	$ 32.80
2%	2 540	$ 65.50

Other considerations

Equity in the hospitality industry

Cost-effectiveness analysis is concerned primarily with the relationship between costs and effects: that is with efficiency. Issues relating to the distribution of costs or benefits, ie equity, need to be considered separately. Two concepts of equity can be distinguished. The first of these is horizontal equity which relates to the equal treatment of equals. This concept suggests that venues serving similar purposes within the hospitality industry ought to be treated equally. Thus, restaurants ought to be treated the same as hotels serving food while clubs may be regarded as close substitutes to bars. The second concept of equity is known as vertical equity. This refers to the unequal or different treatment of unequals. Thus, venues serving different purposes or different clientele might argue that they ought to be treated differently in recognition of the special characteristic that each possesses.

In the context considered here, public health legislation without exemptions might be considered fair, in terms of horizontal equity, as all venues are treated equally and the relative competitiveness of individual venues is not affected favourably or adversely. In contrast, selective regulation (ie option 4) which allowed exemptions on the basis of location, clientele or function for example, might also be considered fair, this time in terms of vertical equity.

Thus different views of what equity means leads to different opinions on the relative merits of the options being considered. In short, no option is clearly better in terms of its equitable treatment of venues in the hospitality industry.

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Cross border issues

It has not been possible to consider the impact that the options to reduce exposure to ETS might have on venues located in towns which are close to State borders. What evidence there is available from experience in the USA suggests that any outflow of people away from areas in which there are smoking restrictions in place is offset by a compensating inflow of patrons keen to dine and drink in a smoke-free environment (Masotti and Creticos, 1992).

Phasing in of regulations

A phasing-in period for the chosen option might be desirable for two reasons - to allow the public information campaign time to work and to allow operators time to make the necessary structural changes to venues.

Structural alterations could take some time to work through the industry especially if allowance is made for venues which have recently finished new capital works. However, the need for structural work only arises with option 4 (and possibly option 2 if venues choose to respond in this way to the increased pressure of litigation). Phasing in would allow the costs of structural work to be spread over a longer time period making this a more affordable option but it will have only a small effect on total costs. Economies of scale could be realised by incorporating the installation of ventilation equipment into routine structural renovations and repairs but the savings are likely to be less than 10% of the total cost (Broadbent - personal communication).

Public acceptance of no-smoking regulations is higher in restaurants than in hotels or licensed clubs (Schofield and Edwards, 1995; Semmonds et al, 1995). The need to allow the education campaign time to take effect provides a rationale for phasing in new regulations by sector as in the ACT introducing restrictions in restaurants first and pubs and clubs later. Any advantages gained by phasing in implementation needs to be offset against the consequences that delay has on the effectiveness of intervention. As table 3 indicated, 65% of the staff at risk of exposure to ETS work in the hotels and licensed clubs sectors of the hospitality industry. The levels of ETS are also likely to be higher in these sectors, increasing the risks of exposure accordingly (Siegel, 1993).

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Conclusions

Of the five options considered here, no one option is clearly more effective and less expensive than the others. If effectiveness is defined solely in terms of the likely health impact then option 4 is dominated by both options 3 and 5. That is, it is both more expensive and less effective than either of these alternatives. It does, however, offer other features which some may deem beneficial and hence valuable in that it lets tobacco users continue to smoke while they eat and drink. The cost of this option depends on the extent to which venue operators decide to install ventilation equipment. Most of the additional cost is therefore borne privately and so it could be argued venue operators ought to be allowed to let commercial interests determine whether or not they prohibit smoking. However, ventilation is not 100% effective at removing the toxic components of ETS and so part of the 'cost' of this option will continue to be borne by staff members. While there is no economic reason why option 4 should be ruled out, the continuing risk faced by employees may be sufficient reason for excluding it for on public health grounds.

Of the remaining options, the more effective interventions are also the more expensive ones. A policy recommendation then depends on two factors. First, 'how much more effective will the better options actually be?' and second ' is the increase in effectiveness worth the additional costs involved given competing demands on the same resources?'. The big unknown is the effectiveness of enhanced OHS legislation which, of all the active interventions, is the least imposing and the least expensive. OHS legislation has been effective in other workplaces though not in the hospitality industry. If the enhancements envisaged under option 2 can overcome the current stalemate then this would probably be the preferred option.

Public health legislation overcomes this problem and removes any uncertainty over future litigation. The large investment in implementation makes it a costly option, however and one would probably need to be pessimistic about the effectiveness of option 2 before considering it worthwhile. If this option were preferred it would probably be necessary to revise the existing OHS legislation in any case and so there may effectively be no choice between option 3 and 5.

In summary, on the basis of the information and assumptions presented here, no clear cut conclusion emerges from the economic evaluation. It is hoped, however,

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that by making explicit at least some of the costs and consequences that whatever decision the taskforce eventually settles upon, whilst not made any easier will be seen to be considered and open to scrutiny.

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Acknowledgements

A number of people gave freely of their time to provide the information necessary to compile this report. I am particularly grateful to the following people for the help that they provided: Stephen Bannister and Adam Jones of the Registered Clubs Association; David Charles of the Australian Hotels Association; Warwick Hough of the Restaurant and Caterers Association of NSW; Peter Harley and Rod McGuinness from Workcover; Lucy Burns, Kate Purcell and Desmond Crowley of the NSW Health Department; Margot Goodin, ACT Health; Patrick Stakelum, Head of Research and Statistics in the Office of Finance and Management, ACT; the statistics and information service run by the Bureau of Tourism Research in Canberra; Dr Paul Morrison, Senior Lecturer in the Department of Business Studies at the University of Queensland; Janelle Seymour of CHERE for research assistance; Clive Broadbent, and finally; Bev Carroll. I am also grateful for the comments provided on an earlier draft of this paper by members of the NSW Passive Smoking Taskforce under the chair of Dr Andrew Penman.

As always, all ideas expressed in this paper and any remaining errors are the responsibility of the author.

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APPENDIX 1 Review of the Financial Impact of No-Smoking Ordinances

Introduction

This appendix provides a brief review of studies which purport to examine the financial impacts of smoking ordinances. All of the studies referred to here originate in the USA. The studies generally fall into one of two groups. Among the better are those that rely upon sales tax receipts and use multivariate statistical methods to assess the effect on restaurant revenues before and after the introduction of a smoking ordinance. The second category of study uses survey methods to assess behavioural intentions or expectations about the impact of smoking ordinances. Only the former are reviewed here. Surveys of behavioural intention are notoriously poor at predicting behaviour. In contrast analysis of sales tax data provides a valid check on the consumption behaviour of restaurant and hotel patrons.

Methods

Study references were obtained from a number of sources. A number of references were supplied by members of the task force. The bibliographies in these articles were then used to identify any further papers. A Medline search was also carried out using the search terms "smoking control", "environmental tobacco", and "restaurants". Finally, resources listed on the internet were scanned for additional information.

Results

Table A1 summarises the studies which analyse changes in sales receipts before and after the introduction of a smoking ordinance. Only two of the studies appear in peer reviewed papers. The rest are non-reviewed reports and mimeographed papers. Few papers provide sufficient details of the methods employed and so critical review was difficult. Follow-up is frequently too short with many studies relying only one-quarter's post-ordinance sales revenue. Thus, few of the studies control for temporal influences on consumption patterns or long term changes in the macro-economic climate which will also affect consumer spending.

Despite these problems, the studies are almost unanimous in concluding that the introduction of smoking ordinances in various parts of the USA has had little or no discernible effect on the revenues of restaurants. Two studies report small reductions in revenue in one quarter but these are consistent with random variation in income (Laventhol and Horwath, 1990; Pope and Bartosch, 1995). One paper reports a substantial downturn in income (Masotti and Creticos, undated). This study was unable to control for other influences on consumption patterns and was flawed in using incorrect data. Maroney et al (1994) suggest that the drop in restaurant revenues disappeared when revised data issued by the State Board of Equalization was used instead.

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TABLE A1 Summary Results of Studies Using Sales Receipts Data

STUDY	SOURCE	SAMPLE	ORDINANCE PERIOD	METHOD	DEPENDENT VARIABLE	CO-VARIATES
CDC (1995)	MMWR	8 restaurants / 1 city	19 months	OLS regression	Total restaurant sales	seasonal variable secular trend economic trend
Glantz and Smith (1992)	Mimeo	4 ordinance cities (CA) and 4 controls	4 - 11 months (mean = 7 months)	Linear regression	Restaurant : retail sales ratios	Not reported
Glantz and Smith (1994)	American Journal of Public Health	15 ordinance cities (CA) and matched controls	5 - 95 months (mean = 31 months)	Linear regression	Restaurant : retail sales ratios	secular trend seasonal variable
Laventhol and Horwath (1990)	Not available	1 city (CA)	3 months	Not available	Sales tax	Not available
Maroney et al (1994)	Mimeo	19 ordinance cities (CA) plus 87 neighbouring cities	Not specified (> 9 months)	Not specified	Sales data	prior restaurant sales retail sales no of restaurants city population county unemployment personal income
Masotti and Creticos (n.d.)	Mimeo	1 city (CA)	4-5 months	Not specified	Sales tax receipts	Not specified
Pope and Bartosch (1995)	Mimeo	1 city (MA) plus 4 control communities	3 months	Multivariate time-series analysis	Monthly sales receipts	Not specified
Sciacca et al (forthcoming)	Mimeo (under review)	1 ordinance city, neighbouring areas and state aggregate	18 months	Unspecified time-series analysis	Restaurant : retail sales ratio	Not specified
Taylor Consulting (1993)	Mimeo	1 city (CA)	> 15 months	Unspecified time-series analysis	Sales tax receipts	Not specified

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TABLE A1 (continued)

STUDY	RESULT	COMMENTS
CDC (1995)	Total sales of restaurants did not decrease after ordinance introduced	Study excluded restaurants that opened during study period. Results not generalisable to all West Lake Hills' restaurants.
Glantz and Smith (1992)	Ordinance had no significant effect on total restaurant sales	Incomplete copy of paper reviewed. Brief post-ordinance period studied.
Glantz and Smith (1994)	Ordinance had no significant effect on proportion of retail sales received by restaurants	Data validated by State Board of Equalization or Dept of Revenue. Reflects all restaurant sales in community. Time span enables control of secular trends.
Laventhol and Horwath (1990)	7% reduction in sales	Note: report not available for review. Comparison of one quarter pre and post ordinance with no control of secular factors or other co-variates.
Maroney et al (1994)	No discernible change attributable to ordinance	Summary of report only available for review.
Masotti and Creticos (n.d.)	26% fall in revenue in one full quarter following ordinance. 'Softening' of receipts attributed by owners to economic downturn not ordinance	Apparent fall in revenue due to incorrect data. Report does not detail the methods employed.
Pope and Bartosch (1995)	3% fall in receipts	Fall within normal fluctuations but margin for error is wide (-9.7% to +4.0 %). No details of statistical techniques employed.
Sciacca et al (forthcoming)	No evidence that prohibiting smoking adversely affected restaurant sales	Abstract of paper only available for review. Manuscript currently under review
Taylor Consulting (1993)	Ban had no significant effects on the profitability of restaurants and bars	No details of methods provided.

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SECTION 8

ECONOMIC IMPACT OF SMOKE FREE PUBLIC PLACES LEGISLATION

The following discussion is based on evidence obtained from a range of studies conducted in the United States (US) on the economic impact of US legislation aimed at restricting smoking in public places. The discussion looks at the effect on Restaurant and Bars sales and Tourism and Business.

Restaurant and Bars Sales

Glantz and Smith, "The Effect of Ordinances Requiring Smoke free Restaurants on Restaurant Sales."[15]

This study analyses sales tax data for the first 15 US cities to enact smoke-free ordinances affecting restaurants. They also examined sales tax data from 15 comparison cities similar to the smoke-free cities in population, income, smoking prevalence and other factors.

This study explored the common concerns raised about the possibility that patrons will dine in adjacent communities without such restrictions. The analysis did not detect any adverse pattern in this area.

The study looked at the effect on bars. Revenues from bars and "full service" restaurants were included in sales tax data. The ordinances examined in the study contained different provisions governing bars independently and bars in relation to restaurants. No significant effect on sales was detected in this study.

The study noted two important findings on the two cities which subsequently repealed their ordinances (Bellflower and Beverly Hills):

> While the ordinances were in effect, neither smoke free ordinance caused a drop in restaurant sales; and
>
> Neither city experienced an upsurge in restaurant sales following repeal of the ordinance, as would be expected if the ordinance had depressed restaurant sales.

The three Colorado cities of Aspen, Snowmass Village and Telluride are popular ski resorts, which rely heavily on tourist trade. None of these cited experienced a drop in sales following adoption of their ordinances.

Therefore, this study found that the presence of a 100% smoke free restaurant ordinance:

* Had no significant effect on total restaurant sales in any community;
* Was associated with a small (1%) but statistically significant increase in the fraction of total retail sales that went to restaurants (i.e., restaurants became more competitive for retail dollars spent in the community); and
* Had no significant effect on the ratio of restaurant sales in communities with no

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such restrictions.

The Impact Of Tobacco Control Ordinances on Restaurant Revenues in California. Maroney,N; Sherwood,D; Stubblebine,WC; Claremont Institute for Economic Policy Studies.[116]

This sample in this study consisted of Californian cities with ordinances enacted before the end of 1991 requiring more than 50% of restaurant seating to be no-smoking and their surrounding cities. Of the cities included in the study, 11 ordinances specified no-smoking seatings and 9 ordinances banned all smoking in restaurants.

Sales tax data from 1986 through to the third quarter of 1992 were collected for 106 sample cities. The study found:

* Restaurant revenue changes could not be attributed to ordinance smoking restrictions. Ordinances had no consistent effect on restaurant revenues, regardless of the percentage of no-smoking seating required;

* Surrounding cities without ordinance restrictions exhibited significant fluctuations in revenues that could not be distinguished from those of ordinance cities;

* Significant shifts in restaurant patronage between ordinance and surrounding cities could not be attributed to smoking restrictions; and

* The time of the ordinance adoption and other city-specific characteristics such as geographic location, dining opportunities in surrounding cities, and determinants of smoking prevalence (median income, age and ethnicity) could not be held responsible for significant revenue changes.

These results imply that other variables not accounted for in the model affecting one or more cities in a local area also contributed to revenue changes during the time ordinance effects were assessed.

Taylor Consulting Group : A Study of the Economic Impacts on San Luis Obispo Restaurants and Bars 1993. Submitted to the City of San Luis Obispo, Smoking Ordinance Economic Analysis Steering Committee.

This study analysed the effect of the San Luis Obispo ordinance, which eliminates smoking in restaurants and bars. In addition to an analysis of sales tax data similar in scope to the Glantz and Smith studies, restaurant and bar owners and patrons were surveyed. No evidence of negative economic impact on San Luis Obispo restaurants or bar sales was found. Furthermore, sales in neighbouring cities did not increase when the ban was instituted. It was reported that most smokers are more often going to out-of town restaurants and bars, while non-smokers are more likely to go to San Luis Obispo establishments. These two shifts offset one another such that there is no net sales impact.

It was also reported that some restaurant and bar patrons who are smokers have shifted to establishments with outdoor facilities, and some restaurant and bar owners have reacted by expanding their outdoor capacity.

The San Luis Obispo study by the Taylor Consulting Group found that 48% of the visitors surveyed knew of the ban prior to their current visit: smokers were equally

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aware of the ban as non smokers. None of the smoking visitors, almost half of whom were aware of the ban before visiting, reported avoiding San Luis Obispo because of the ban.

Sciacca, John, (1996), A Mandatory Smoking Ban in Restaurants: Concerns versus Experiences, Journal of Community Health, 21(2), p: 133-150.
A study conducted at the Northern Arizona University found that the city of Flagstaff's smoke free restaurant ordinance had no negative impact on restaurants, as measured by sales tax data. A survey of restaurant owners found that while owners expressed apprehension before the ordinance went into effect, 15 months later 94% reported the ordinance as easy or very easy to enforce.

Centres for Disease Control and Prevention -, Assessment of the Impact of a 100% Smoke-free ordinance on Restaurant Sales, Morbidity and Mortality Weekly Report, 44(19):370-372, 1995.
Researchers at the Center for Disease Control and Prevention analysed restaurant sales tax data and found that the total sales of the restaurants did not decrease after implementation of the ordinance banning smoking restaurants in West Lake Hills, Texas.

Pope, Gregory and Bartosch William,The Economic Impact of Brookline's Restaurant Smoking Ban, Waltham, MA Health Economics Research, Inc, November 1995.
A study by Health Economic Research found that Brookline's smoke free restaurant ordinance did not have a significant, immediate effect on the city's restaurant patronage.

Aspen Resort Association, "Business Update, October 1986 through March 1987: Aspen/Pitkin Environmental Health Department, November 29, 1990.
Monthly studies conducted by the Aspen Resort Association found that total retail sales, including restaurants, actually increased after the City's 100% smoke-free ordinance went into effect. A study conducted by the Aspen/Pitkin Environmental Health Department found broad support for the ordinance among restaurants and retailers, and 'no negative effect on business whatsoever.'

Taskforce for a Smoke-free San Diego,"The Economic Implications of a Smoke-free San Diego on Convention Business.
A 1992 survey of convention groups that came to San Diego in 1991-92 found that 38 of 40 conventions, representing 168,140 delegates, would continue to schedule conventions in San Diego if the city adopted a smoke-free restaurant ordinance.

Corsun D., Young C. & Enz C. 1996 Should NYCs Restaurants Lighten Up? Hotel and Restaurant Administration Quarterly, April, p:23-5.
This study analysed changes in dining behaviour, attitudes toward and tolerance of smoking, spending patterns, demographics, and feelings about New York City's Smoke-Free Air Act. The sample consisted of 389 patrons of NYC restaurants who were asked to comment on any changes to their dining habits since the passage of the Act. Results of the study were therefore based on subjective data. The main results of the study are that smokers reported dining out less and said that they took less time to dine when they did dine out. However, non-smokers report dining out more frequently since the Act went into effect and most were taking the same time to dine as they did prior to implementation of the legislation. On the whole, therefore, the population of New York City restaurants has not been negatively affected economically by the legislation.

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Price Waterhouse; San Diego Tavern and Restaurant Association Study; 1992.
Price Waterhouse undertook a survey for the San Diego Tavern and Restaurant Association in 1992 , estimating the potential loss of jobs and tax revenues in the restaurant and convention business sectors, if the city of San Diego passes a 100% smoke free ordinance. This survey asks for owners and managers of restaurants to **'predict'** the effect they expected from the ordinances; "At least 48%" predicted a decrease in sales while 'approximately"40% expected no change in sales. Of those who predicted a loss in sales, the average decrease was 37.2%.

It should be noted that their findings are not based on the more objective measures such as the analysis of sales tax data over time.

Lilley, W & DeFranco L. Restaurant Jobs in New York City, 1993 Through First Quarter 1996, and the Restaurant Smoking Ban. Prepared for the Empire State Restaurant and Tavern Association 1996

This study analyses the number of restaurant jobs before and after the introduction of passive smoking legislation and concludes that the legislation is associated with a decrease in the number of these jobs. However the study results are flawed on two main grounds. Firstly, there is no attempt made to control for other issues that could account for the decrease in restaurant jobs during the period under study. For example, there may have been a change in licensing fees, liquor laws etc that can account for the changes. Secondly changes in employment are examined for the period March 1993 to March 1995. However, as the law took effect in April, 1995, no comments can be made about the effect of introducing this legislation.

In summary, the results of this study cannot be taken as evidence that passive smoking legislation affects jobs in the restaurant industry because the time periods analysed do not correspond with introduction of the legislation and no other confounding variables have been controlled.

Price Waterhouse LLP Potential Impact of Increased Smoking Restrictions in New York City, December 1994, Sponsored by United Restaurant. Hotel. Tavern Association of New York State

This study is an attempt to analyse the potential impact of increased smoking restrictions on eating places, hotels and motels and visitor and convention delegate expenditures. The method used to gain the information was a survey of the managers of businesses in New York City. No further information is given about the sample or methods of data collection. The authors state that the managers of businesses are a valid source of information as they know the behaviour and smoking preferences of their customers.

This article claims to be evidence that the introduction of a Smoke-free Air Act in New York City would lead to a decrease in sales. However, the methods used in the survey are based on the opinion of a non-randomly selected group of people about the potential action of another group of people and for this reason this study is flawed and the conclusions must be viewed with caution.

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SECTION 9

DISCUSSION OF POLICY OPTIONS

In line with their third term of reference, "... to identify and assess a range of strategies, including non-regulatory strategies, for eliminating exposure to passive smoke in areas where food and beverages are consumed", the Taskforce considered a range of policy options and strategies aimed at eliminating community exposure to passive smoking.

To assist the Taskforce in their consideration of these options, the Taskforce was informed by the evidence on the health effects of passive smoking which highlighted information relating to:

those segments of the population most at risk; and

the relationship between the dose of ETS and the duration of exposure and level of risk.

The Taskforce also considered:

evidence presented by independent experts who examined a range of ventilation issues and current options to address the risks associated with ETS exposure;

submissions and presentations from a range of key organisations including the tobacco industry and the general public;

submissions from ventilation companies which produce air filtration products;

the results of public opinion surveys;

the structure of the hospitality industry in NSW;

a complex range of legal issues;

the initiatives undertaken by other states in Australia and by other countries to address this issue; and

the evidence relating to economic impact of strategies to reduce ETS exposure.

This material is discussed in the earlier sections of the report. The Taskforce undertook an extensive public consultation process and invited presentations by key stakeholders. As a result of these processes, the Taskforce identified five policy options for consideration:

OPTION 1 Maintaining the status quo

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OPTION 2 **Strengthening of Occupational Health and Safety controls**

OPTION 3 **Introduction of legislation to ban smoking in indoor places where food and beverages are consumed**

OPTION 4 **Introduction of legislation to ban smoking in indoor places where food and beverages are consumed with exemptions permitting smoking in separately ventilated smoking rooms**

OPTION 5 **Introduction of legislation to ban smoking in indoor places where food and beverages are consumed and strengthening of Occupational Health and Safety controls**

The Taskforce explored the effectiveness of each of these options in eliminating the exposure of the public and employees to passive smoking in the hospitality industry. The Taskforce was mindful of the following issues:

I. Health Risks associated with ETS

The Taskforce recognised that the health effects of passive smoking have been the subject of many scientific studies and reviews by major health authorities. The terms of reference of this Taskforce did not allow the Taskforce to undertake a comprehensive evaluation of the scientific and medical evidence relating to the health effects of ETS. This task is more appropriately the responsibility of other working parties convened for this purpose. The Taskforce did find it necessary to examine many of these studies and reviews to inform and assist it with its task of identifying options to eliminate exposure to passive smoking in the hospitality industry.

The Taskforce also identified employees working in the hospitality industry as a particularly vulnerable group who are regularly exposed to ETS from smoking patrons throughout their daily working shifts. The Taskforce found that exposure of these employees to ETS was a significant Occupational Health and Safety issue.

Research has indicated that:

The relative exposure to ETS for bar and restaurant employees is much higher than for employees in other businesses or for individuals who live in a home with a smoker;[117]

Employees spend a much longer time in these environments than do patrons and are therefore more likely to suffer adverse health effects; and

Exposure to concentrations of ETS in workplace air is likely to be at least 1.5 times higher for restaurant workers than for persons who live with a smoker, and at least 4.4 times higher for bar workers than for individuals with only domestic ETS exposure.

There is an excess lung cancer risk of approximately 50% (range 10% to 90%) in food-service workers compared with the general population, controlling for active smoking;

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The Taskforce was also concerned about the risks to the general public who were particularly vulnerable to adverse health effects following short term exposure (eg. adults with asthma, heart disease, diabetes and chronic airways diseases and children).

The Taskforce was therefore particularly concerned to consider the effectiveness of each of the policy options in eliminating exposure to ETS for both employees and the general public.

Discussion of the health effects of environmental tobacco smoke is found in Section 1.

ii. Legal Issues

The Taskforce explored a range of complex legal issues. Legislation currently exists which addresses smoking in certain public places for the purposes of public safety and in areas where food and beverages are prepared and served for the purposes of hygiene. These include the Food Act 1989 and various regulations which ban smoking by patients and visitors in dining areas of nursing homes, day procedure centres and private hospitals.

The Food Act 1989

The Taskforce considered the relevance of the Food Act in relation to the issue of smoking by the public where food and beverages are consumed. The Taskforce identified weaknesses concerning the interpretation of clause 26 and the difficulty in applying this clause to include smoking by the public in places where food and beverages are consumed. The difficulty lies in the definition of what areas are considered as places where food is handled for sale. Smoking is not prohibited by the Food Act in areas or places where food is not handled for sale such as a foyer area or a lavatory of the restaurant or hotel and although a restaurant, dining room of a hotel or eating establishment in which food is served at a table and consumed might be a place where food is handled for sale it is difficult to conclude that it applies to a customer in that area.

The Taskforce was also informed that for other workplaces, employers are at risk of claims from staff and others in the workplace under the Workers Compensation Act 1987, the Occupational Health and Safety Act 1983 (NSW) and common law. The Taskforce was provided with legal advice concerning the interpretations of the following workplace legislations:

Occupational Health and Safety Act 1983 (OHS Act)

Section 15 of the OHS Act obliges all employers to ensure the health, safety and welfare at work of their employees.

Section 16 of the OHS Act places a duty upon employers to ensure that persons other than their employees are not exposed to risks to their health or safety while at the employer's place of work.

Section 17 of the OHS Act obliges persons in control of non-domestic workplaces to ensure the health and safety of non-employees.

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Section 19 of the OHS Act provides an equal obligation on employees to work safely.

The Taskforce was also informed of the existence of a draft Code of Practice in respect of passive smoking and the Guidance Note on Passive Smoking which are regarded as recommendations and set guidelines for employers and is a 'support tool' for the OHS Act.

In a prosecution under the Occupational Health and Safety Act it would have to be proved beyond reasonable doubt by the prosection that the employer had not ensured an employees health, safety and welfare at work because of ETS being in the workplace.

The majority of the Taskforce recognised that exposure of employees in the hospitality industry to ETS was a significant Occupational Health and Safety issue.

Common Law

The Taskforce was informed that under Common Law, a duty of care exists to those who may suffer harm from a person's acts or omissions. The common law imposes an obligation on employers to take reasonable care of the safety of their employees. The obligation extends to the provision of safe places of work and safe systems of work.

Discussion of legal issues is found in Section 2.

iii. International Initiatives

The Taskforce undertook a comprehensive examination of legislative developments and initiatives in other countries. It was found that:

- there is an increasing level of legislative action by countries to protect the health of their communities from smoking in public places;
- numerous sub national jurisdictions -state, provinces, counties, cities and towns - have adopted legislation to ban or restrict smoking in public places including hospitality areas;
- in some jurisdictions, such as in some states and counties of the United States, certain segments of the hospitality industry are dealt with differently by the local ordinances. This has included applying smoking restrictions and bans in dining areas but not in bars or bar areas or restaurants, applying smoking restrictions according to the size of the venue, and designating certain areas as smoking areas such as outdoor if available. The examination found that some counties, towns or states:
    - * ban smoking in restaurants but not in bars or bar areas of restaurants, such as San Francisco and New York State;
    - * ban smoking in restaurants but not in enclosed bars or bar areas of restaurants such as Sacramento;
    - * designate smoking areas in restaurants and bar areas with 50 or more seats such as in local counties in Florida;

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* prohibit smoking in bars and bar areas of restaurants if they cannot prevent smoke filtering into the eating areas through a passageway, ventilation system, or other means such as in Novato, Belvedere;

* restrict smoking to 50% of outdoor areas such as in San Buenanventura;

* ban smoking in all restaurants and bars such as in San Luis Obispo; and

* in Toronto, Canada, smoking will be banned in all restaurants and bars from 1st January, 1997.

Discussion of international initiatives is presented in Section 3.

iv. The Structure of the Hospitality Industry In NSW

The Taskforce examined the structure of the hospitality industry in NSW and identified the areas that would be affected by strategies to eliminate exposure to ETS in the hospitality industry. The Taskforce considered that the industries directly affected by their recommendations would include:

Restaurants and cafes;

Food halls and eating areas in shopping centres;

Function Centres;

Night Clubs;

Private functions which are commercially catered and held in public places;

Theatres which provide cafe and bar facilities;

Areas of attractions such as theme parks and zoos where food and beverages are served;

Areas of Hotels and motels where food and beverages are served;

Hotels and pubs;

Guest Houses, and other forms of accommodation offering areas where food and beverages are served and consumed;

Registered clubs; and

The Casino.

The Taskforce concluded from the evidence it considered that there were no public health grounds to treat eating and drinking facilities differently. The Taskforce therefore considered recommendations across the hospitality industry as a whole to ensure adequate health protection for all employees and patrons and to avoid giving particular segments of the industry economic advantages compared to other segments. For this reason, recommendations for the separation of eating and drinking facilities as well as

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those internal to the establishment (which was found to be a characteristic of some international legislative action) have not been provided by the Taskforce. The substantial differences between segments of the industry were acknowledged. Therefore, the options considered by the Taskforce include all indoor places where food and / or beverages are consumed.

Discussion of the structure of the hospitality industry is found in Section 4.

v. Public Opinion Surveys

The Taskforce noted the many public opinion surveys which consistently indicate strong support for banning smoking in the restaurants and cafes. Less support was indicated for banning smoking in hotels and clubs.

These include:

The 1995 NSW Health Promotion Survey which found 95% of the public supported restrictions or bans on smoking restaurants and 82% supporting the same for clubs and hotels;

The 1993 Australian National Household Survey which found 73% of respondents favoured smoking bans in restaurants and 70% in shopping centres;

The 1993 NSW Quit Campaign survey which found 72% of respondents supported banning smoking in shopping centres, 82% supported smoking bans in restaurants and 83% supported banning smoking in all public places;

A survey[118] conducted in 1993 reported that customers were much more likely than owners to think smoke-free areas should be provided;

Semmonds et al[119] found in their survey 60% of hotel patrons favoured the establishment of smoke-free areas.

Discussion of public support and public opinion surveys is found in Section 4.4.

vi. Ventilation

The Taskforce commissioned an independent investigation to examine the role of ventilation in addressing exposure to environmental tobacco smoke (ETS) in the hospitality industry. The Taskforce also received and considered submissions and presentations from companies currently involved in the ventilation industry.

The Taskforce was informed of the following key factors:

1. Environmental Tobacco Smoke is complex and contains over 4,700 different chemical constituents, both gases and particulates;[120]

2. Particles in tobacco smoke are especially hazardous because they are inhalable and remain airborne for hours after smoking stops;[121]

3. The presence of ETS is most obvious when smokers are present in the room, but

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can also arise from air movement around the building (including transmission by recirculation ventilation systems) and 'off-gassing' from surfaces after smoking has ceased;[122]

4. Current ventilation standards such as AS 1668.2 are comfort standards aimed at controlling odour and do not address health - related issues;[123]

5. Air-cleaning devices are commonly used in general air conditioning systems, however they are ineffective in removing all the particulates in ETS and most cannot remove all the gaseous components;[124]

6. Filtering efficiency of ventilation systems often diminish with time and the devices used require regular servicing. Carbon filters, or ozone treatment of the air, can remove many gases and vapours but also need regular maintenance and do not remove all the pollutants. Thus, air-cleaning devices, while offering some improvement, do not provide full and reliable protection from the risks of ETS exposure to employees and the public.[125] This was acknowledged by the representatives of one company which manufactures air filtering equipment at their presentation to the Taskforce;

7. Ventilation improvements to attain a level of outdoor air ventilation considered acceptable in terms of risk level for ETS exposure for enclosed areas in which an excess of ETS is present (such as restaurants and bar areas), would result in extremely high air flow rates which are impractical in real-world applications. Where smokers and non smokers are co-located it was estimated that this would cost approximately $30,000 per smoker to install and does not include costs for ongoing maintenance.[126]

8. Broadbent and Wesley state that the establishment of separate ventilated smoking rooms where outdoor air and exhaust air facilities are completely separate from facilities serving non-smoking rooms, is the only approach to offer the degree of ventilation control required for ETS to be kept to an acceptable level. They estimate installation costs for a 70 person (where 17 patrons are smokers) restaurant of 100 m2 floor area to be approximately $12,000. This cost does not include heating or cooling provisions.

9. The health risks associated with passive smoking exposure in outdoor areas are dependent upon factors such as variable air velocity; and lack of wind shelters/barriers which assist in the dilution of cigarette smoke.

Current Practices

The following range of current practices operating in NSW were examined in the report by Broadbent and Wesley and considered in detail by the Taskforce members:

Physical separation of non-smokers from smokers
(ie provision of non-smoking areas).

The consultants concluded that this approach is ineffective in reducing ETS exposure to a safe level because of the diffusion of smoke throughout all areas of an enclosed room and into other areas of the building. These findings are consistent with the conclusion of the 1986 report of the US Surgeon General that "the simple separation of smokers and non-smokers may reduce, but does not eliminate, the exposure of

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non-smokers to environmental tobacco smoke".[127]

Programs which focus on the "courtesy approach"

The consultants found these programs to be ineffective in reducing exposure of ETS because of the diffusion of ETS to other non-smoking areas. Their report cited surveys from the US and Australia indicating that despite the fact that the majority of those surveyed found breathing other people's smoke was annoying to them, very few would say anything to the smoker.

Voluntary Policies where patrons choose to frequent establishments which are either smoking or non-smoking

These were considered by Broadbent and Wesley who stated that these policies do not address the issue of significant exposure to employees and patrons from those establishments which permit smoking.

Broadbent and Wesley also considered the following options:

> *Permitting smoking and non-smoking areas provided ventilation equipment of a particular standard is installed.*

This is the approach currently adopted by the A.C.T.
The report concluded that the ETS generated by smokers when the ratio of smokers to non-smokers is 1 in 4, greatly overwhelms the ability of a ventilation system to reduce the ETS levels to an acceptable health risk level.[128]

> *Permitting separately ventilated smoking rooms where outdoor air, (with or without recirculating air), and exhaust air facilities are provided. These ventilation systems are completely separate from facilities serving non-smoking rooms was also examined.*

Broadbent and Wesley concluded that this approach would be judged as the only one to offer the degree of ventilation control required for ETS to be kept to an acceptable level although care would need to be taken to ensure that smoke does not "leak back" into the non-smoking rooms. They recommended that designated smoking rooms need to be separately ventilated and under negative pressure and also provided with an airlock.[129] The Report also identified significant installation and maintenance costs associated with this option as well as additional factors such as noise costs and extremely high air flow rates. The report also stated that while there would be improvement in health protection offered to non-smoking patrons this option did not address the significant health risks to employees and patrons exposed to ETS in the smoking room.

The consultants concluded that hospitality establishments being 100% smoke free is the only certain means whereby the hospitality industry patrons and employees are protected from exposure to ETS indoors.[130]

Discussion of ventilation issues is found in Section 5.

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vii. Public Consultation

The Taskforce consulted widely in relation to this issue inviting submissions from the public by placing an advertisement in the Sydney Morning Herald and writing to a range of organisations and personnel. Some key stakeholders were also identified by the Taskforce and invited to make presentations to the Taskforce regarding their views on this issue.

The consultation process undertaken by the Taskforce indicated strong support for action to be taken to address ETS exposure in the hospitality industry. Most submissions highlighted the need for legislative action targeting all aspects of the hospitality industry. Some submissions raised concerns regarding the impact on children directly exposed to ETS and that of "modelling behaviour", the effect on the health of employees, the adequacy of ventilation systems to address the health risk of exposure to ETS and the importance of adequate enforcement and compliance programs for legislation. Other submissions highlighted the importance of the 'culture' of the hospitality industry where smoking plays a large part in people's recreation and leisure behaviour, the potential economic impact on the hospitality industry of any legislative initiatives and the adequacy of existing options available to the hospitality industry such as ventilation and courtesy of choice programs.

Discussion of the public consultation process is found in Section 6.

viii. Economic Impact

The Taskforce commissioned a consultant to undertake an independent analysis of the costs and effects of five options identified by the Taskforce. The consultant concluded that:

(I) There is no option which is clearly more effective and less expensive than the others;

(ii) The more effective options in terms of eliminating the health risks of ETS exposure are more expensive in terms of implementation;

(iii) Whilst public health legislation overcomes the current uncertainty over future litigation, it requires a significant initial investment in implementation compared to the other options;

(iv) The effectiveness of the legislative options is partially dependent on there being effective education and training strategies to ensure compliance; and

(v) The welfare gains which would accrue to those who would prefer to eat in a smoke-free environment after the introduction of smoking restrictions are at least equal to the welfare losses of those who would prefer to be allowed to smoke in hospitality establishments.

Studies of the economic impact of similar initiatives were examined. This examination found that a limited number of studies existed, and those that did were predominately from the United States. The Taskforce was also informed that there is little information on the impact on revenue for bars and hotels as a result of legislative measures to restrict smoking in these situations.

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There is no equivalent evidence available from Australian studies other than a survey of community intentions which suggests that there might be a small net-fall in patronage.[131] However the Taskforce was aware that experience in the US has demonstrated that surveys of intended behaviour are not very consistent with the information on the economic impact on hospitality revenue (as measured by sales tax data) following the introduction of restrictions on smoking in these venues.

The Taskforce noted that segments of the industry service different client groups and it is likely that smoking restriction would be felt harder by those establishments serving populations with higher smoking prevalence, less income and lower levels of secondary education.

Studies that relied upon sales tax data receipts indicated that the introduction of smoking ordinances in various parts of the USA has had little or no effect on the revenues of restaurants. Any reduction in custom from smokers is short-term and eventually off-set by a corresponding increase in patronage from non-smokers and/or the return of smoking patrons.[132]

Discussion of the indicative evaluation of the costs and the effects of the Taskforce options is presented in Section 7.

Discussion of the economic impact of smoke free legislation is found in Section 8.

CONSIDERATION OF OPTIONS

The criteria adopted by the Taskforce in considering the effectiveness of each of these policy options in eliminating ETS exposure included:

* The level of health protection for all employees and patrons;
* Feasibility of implementation;
* Public support;
* Providing equal treatment of the different segments of the hospitality industry;
* Short and long term costs to both industry and Government; and
* Accommodating the preferences of smokers without endangering the health of other patrons and employees.

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OPTION ONE: Maintaining current approach

No further action is required.

Current measures to deal with ETS include:

* Voluntary segregation and use of non-smoking areas;
* Courtesy of choice programs;
* Use of ventilation equipment;
* Monitoring and enforcement of OHS legislation in response to employee complaints; and
* Maintaining existing legal duty of care under common law and the Occupational Health and Safety Act.

Advantages of Option 1:

* No further Government regulation is required; and
* No additional implementation costs would be required.

Disadvantages of Option 1:

* It fails to address health risks to employees or patrons from ETS exposure;
* The legal obligations of employers would remain uncertain in relation to ETS;
* It fails to address public concerns about ETS and the community's support for government action in relation to this issue;
* It is likely that the costs to industry in terms of workers compensation, insurance and legal costs may increase;
* The current system of legal action is ad hoc and would continue;
* It has been estimated that in the future, costs arising from litigation over passive smoking to industry as a whole in NSW could range from $4 million to $80 million. Although less than 1% of the employed labour force in NSW works in the hospitality industry the share of the total cost falling upon the hospitality industry will be considerably greater than suggested by its share of employment because 80% of other workplaces are now smoke-free.

Taskforce Response:

Although some of these activities could be strengthened, this option was not supported by the majority of the Taskforce members who believed it fails to provide protection for all employees and the public from the risks of ETS exposure in those places where food and beverages are consumed.

As a result of the competitive pressures in the hospitality industry venue operators believe that a smoking ban will lead to loss of custom if they alone instigate restrictions on smoking. This barrier to the success of self regulation in the hospitality industry would remain under this option unless any legal action is taken against operators.

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OPTION TWO: Strengthen Occupational Health & Safety Controls

Action:
This could require:

* An education campaign to increase awareness of and support for the legislation; and

* Adopting an updated draft Code of Practice to support the Occupational Health and Safety legislation.

Current legislation which is applicable to the hospitality industry already identifies areas to be designated as no smoking areas. These include the following areas:

Areas where food is prepared;
Lunch rooms and employee recreation areas;
Stairways/stairwells, fire escapes;
Confined and poorly ventilated spaces;
Air conditioning towers;
Areas where air circulation is limited;
Areas in/around lift wells;
In situations where employees handle chemicals; and
Areas where dangerous chemicals are stored such as refrigeration areas.

Key elements of this approach which have been considered by the Taskforce include the attachment of a schedule to the current draft Code of Practice which would provide a list of practices which could assist in minimising the risk of ETS exposure in the hospitality industry. 'Good Practice' measures considered by the Taskforce, include the following examples:

(I) Areas designated as no smoking include:

. Administration and Foyer areas;

. Auditoria where films are being screened; and

. Sport facilities of establishments such as gymnasiums, and squash courts.

(ii) Specific 'good practice' policies could include:

. Limiting smoking to specific times of the day and gradually reducing these times;

. Ensuring smoking areas are situated in close proximity to extraction fans, or in outdoor areas (if available);

. Removing ashtrays from all tables and providing them on request;

. Ensuring customers are given the option of dining in a smoking or non-smoking section (if available) when they make a booking;

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- Ensuring that ventilation equipment is regularly serviced according to manufacturers instructions;

- Ensuring staff are rotated between smoking and non-smoking areas; and

- Establishing outdoor areas such as beer gardens, verandahs, and balconies as smoking areas.

Advantages of Option 2:

* This option may clarify the uncertainty of industry in regard to the legal obligations under the OHS Act in relation to ETS exposure;

* It would utilise the existing enforcement structure within Occupational Health and Safety legislation to monitor compliance and enforce the Act; and

* Implementation costs are lower than all other options apart from maintaining the status quo.

Disadvantages of Option 2:

* It does not eliminate the uncertainty experienced by the venue operators in terms of their legal obligations;

* In every prosecution it would have to be proven beyond reasonable doubt that ETS was a risk to employees. This would involve calling expert witnesses for every prosecution which would therefore result in high enforcement and legal costs.

* There is no certainty or control of the time frame for legal action to achieve the elimination of ETS. It is likely there would be extended periods of time where smoking in these venues would continue and the risks of ETS would not be addressed;

* It does not eliminate the health risks for all employees and patrons;

* It does not address smoking by the patrons;

* Industry may have difficulty enforcing the requirements of a strengthened OHS legislation, when there are no legal requirements for patrons not to smoke;

* Costs to industry in terms of workers compensation, insurance and legal costs may increase; and

* Cost to Government through WorkCover and the courts in dealing with ETS compensation claims will continue and may increase.

Taskforce Response:

This option was not supported by the majority of the Taskforce. The effectiveness of this option depends on changing industry perceptions of the likelihood of legal action being successfully taken. Under this option it would be the threat of litigation which

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

would lead venues either to ban smoking or provide ventilation, this would require lengthy and costly legal cases involving the hospitality industry.

The majority of the Taskforce was concerned that this option does not offer protection to the majority of employees and patrons from ETS exposure in the hospitality industry.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

OPTION THREE: Introduce public health legislation to prohibit smoking in indoor places where food and beverages are consumed

Action:

The option could include either:

* Amending current legislation such as the Food Act or the Public Health Act; or

* Introducing a new Act which would ban smoking in indoor areas where food and beverages are consumed;

* Designating appropriate enforcement bodies which could include environmental health officers, local councils, and WorkCover inspectors.

Advantages of Option 3:

* It provides a single piece of legislation that impacts on employers, employees and the public;

* Covers those hospitality industry situations with no employees (sole traders) which are currently only covered by Section 16 of the OHS Act.

* It would eliminate the health risks from ETS exposure for all employees and patrons;

* It address the concerns of the public about ETS exposure and supports their call for government action in relation to this issue;

* It will remove the need for industry to purchase expensive ventilation equipment to deal with the problem. This will be particularly advantageous to those venues which are operating on marginal returns;

* It provides a consistent 'level playing field' with a common commencement date for all the diverse organisations within the hospitality industry;

* It eliminates the barrier to change imposed by the potential loss associated with being the first operator to introduce smoking restrictions;

* It may result in a decrease in costs to industry in terms of workers compensation, insurance and legal costs arising from ETS exposure;

* It may result in a decrease in costs to government associated with ETS workers compensation claims and the courts;

* It will provide employers with an inexpensive, cost effective solution to the elimination of a complex imported hazard (ETS) in the hospitality industry;

* It aligns the hospitality industry with initiatives to eliminate exposure to ETS in other similar internal situations where food and beverages are served such as :

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Art Galleries
Theatres and Public Halls
Airports
Trains
Ferries (State)
Sydney Opera House
Shopping Centres
Stadia

* It removes the risk of prosecution for industry under either common law or OHS or other relevant legislation (for those that abide by the proposed legislative ban). This may in turn lower workers compensation premiums for the industry by removing an emerging claim source;

* It would be easy than the other options for venue operators to enforce;

* It provides for the designation of specifically defined outdoor areas to accommodate smokers' preferences. Areas could include beer gardens, verandahs, gazebos etc; and

* It is felt that in any enforcement action/prosecution court time and costs would be less than a prosecution under the Occupational Health and Safety Act as the public health legislation would clearly define the offence, the penalty and who is committing the offence. Therefore, it would eliminate the requirement that experts be called in every case to prove the adverse health effects of ETS exposure.

Disadvantages of Option 3:

* The hospitality industry, in close proximity to either Victoria or Queensland, may be temporarily disadvantaged by different legislative arrangements operating in each State;

* It would require additional resources for enforcement for an initial period and may divert temporarily inspectors from other OHS or Public Health objectives;

* Additional resources would be required in the short term for public and employers education programs; and

* Implementation would have to address long held beliefs by certain operators of the impact on different sectors servicing different demographic groups in the community.

Taskforce Response:

The majority of the Taskforce supported this option as it provides health protection for all employees and patrons of the hospitality industry from ETS exposure.

This option avoids the potential discriminatory problems in terms of enforcement and penalties identified in option 5 as it addresses the issue in relation to employers, employees and patrons in one piece of legislation.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

The Taskforce accepts that the success of this option, in terms of compliance with total bans on smoking in public places, is highest where the introduction of the legislation is accompanied by both a general information campaign to increase public awareness and staff training for the industry.

This option also addresses the support by the public for government action to address ETS exposure in the hospitality industry and provides for the equal treatment of all sectors of the industry. As well, this option avoids any additional expense on behalf of the industry for addressing this issue.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

OPTION FOUR: Introduction of legislation to ban smoking in indoor places where food and beverages are consumed with exemptions permitting smoking in separately ventilated smoking rooms

Action:

* Introduce new legislation which would prohibit smoking in all hospitality venues as described in option 3, and

* Allow an exemption to be granted to venues with smoking rooms which are separately ventilated to an appropriate standard.

Advantages of Option 4:

* It would eliminate some of the health risks from ETS exposure for the majority of patrons who choose to frequent the non-smoking room;

* It would reduce some of the health risk for some employees who work mainly in non-smoking areas;

* It address the concerns of the public about ETS exposure and supports their call for government action in relation to this issue;

* It may provide some reduction in costs to the industry in terms of workers' compensation, insurance and legal costs arising from ETS exposure; and

* It may provide some reduction in costs to government associated with ETS worker's compensation claims and the courts.

Disadvantages of Option 4:

* This option would result in an inconsistent approach across the hospitality industry;

* It does not provide protection for everyone from passive smoking as smoke can still spread into the non-smoking areas;

* It would not be available to all premises. This option would be particularly disadvantageous to those venues which are operating on marginal returns or whose building design is inappropriate to accommodate the necessary ventilation equipment;

* It does not address health risks of employees who would be rostered to work in these designated smoking rooms;

* It would involve significant costs to the industry to install and maintain ventilation equipment;

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

* The costs for compliance monitoring of those establishments installing such equipment and enforcement, would be high;

* It would involve additional costs to industry to cover the processing of applications for exemptions;

* Additional resources would be required in the short term for public and industry education programs;

* There would be difficulties with enforcement as infringement of ventilation is not visible to customers and public pressure to comply with restrictions is reduced;

* Some venue operators may install the necessary equipment to gain an exemption but as a cost saving measure, they may not use it or maintain it appropriately;

* There are difficulties in defining an 'appropriate air conditioning standard'; and

* It creates a difficulty for venue operators to accommodate a group of patrons which comprises both smokers and non-smokers in a restaurant environment.

Taskforce Response:

The majority of the Taskforce rejected this option as ventilation is not 100% effective in removing the hazard of ETS exposure. The Taskforce were concerned that under this option, staff rostered in the smoking rooms would still be exposed to ETS and patrons and staff in the non-smoking areas would still be at risk from ETS exposure as smoke escapes to these areas.

The Taskforce was concerned that some sectors of the industry would be disadvantaged in terms of being able to offer their smoking patrons a smoking room.

As well, the Taskforce were concerned with the difficulty of enforcing this option and the ability of the public to comply with the legislation.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

OPTION FIVE: **A two-fold approach incorporating:-**

(i) Introduction of legislation to ban smoking in indoor places where food and beverages are consumed ; and

(ii) Strengthening the Occupational Health and Safety Controls.

Action:

This option could include:

* Amending current legislation such as the Food Act or the Public Health Act; or

* The introduction of a new Act which would ban smoking in indoor areas where food and beverages are consumed; and

* Strengthening of OHS controls. This could involve:

  . the use of a regulation attached to the Act to highlight designated smoking areas; and

  . the alignment of penalties and fines with other relevant legislation.

Advantages of Option 5:

This legislative option would:-

* Cover those places where food and beverages are consumed that are not workplaces such as bingo halls, at sporting events.

* Cover those hospitality industry situations with no employees (sole traders) which are currently only covered by Section 16 of the OHS Act.

* It would eliminate the health risks due to ETS for all employees and patrons;

* It would satisfy public's concern about ETS and address their support for government action in relation to this issue.

* It will remove the need for industry to purchase expensive ventilation equipment to deal with the problem. This will be particularly advantageous to those venues which are operating on marginal returns;

* It will provide employers with an inexpensive, cost effective solution to the elimination of a complex imported hazard (ETS) in the hospitality industry;

* It aligns the hospitality industry with initiatives to eliminate exposure to ETS in other similar internal situations where food and beverages are served such as :

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Art Galleries
Theatres and Public Halls
Airports
Trains
Ferries (State)
Sydney Opera House
Shopping Centres
Stadia

* It removes the risk of prosecution for the industry under OHS or other relevant legislation (for those that abide by the proposed legislative ban), This may in turn lower workers compensation premiums for the industry by removing an emerging claim source;

* It provides a consistent 'level playing field' with a common commencement date for all the diverse organisations within the hospitality industry;

* It provides for the designation of specifically defined outdoor areas to accommodate smokers' preferences. Areas could include beer gardens, verandahs, gazebos etc;

Disadvantages of Option 5:

* The hospitality industry, in close proximity to either Victoria or Queensland, may be temporarily disadvantaged by different legislative arrangements operating in each State.

* It would temporarily require additional resources for enforcement and may divert temporarily, inspectors from other OHS or Public Health objectives.

* Additional resources would be required in the short term for public and employers education programs.

* There is no need to strengthen Occupational Health and Safety legislation to cover the issue of passive smoking in the hospitality industry if smoking is banned under another form of legislation.

* If there were two pieces of legislation governing the same type of conduct, it is doubted that public health legislation would have fines equivalent to Occupational Health and Safety legislation. This opens the way for enforcement to act in a discriminatory way as prosecution under OH and S legislation provides higher fines.

Taskforce Response:

The majority of the Taskforce rejected this option due to the difficulties identified with enforcing two pieces of legislation governing the same type of conduct. As well, the Taskforce were informed that it would not be necessary to address the Occupational Health and Safety legislation, as new legislation would cancel out the concerns raised in relation to the need for improved Occupational Health and Safety.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Recommendation of Preferred Option for NSW to Eliminate Exposure to ETS in Places where Food and Beverages are Consumed

The majority of the Taskforce recommends the adoption of option three **"Introduce public health legislation to prohibit smoking in indoor places where food and beverages are consumed "** as the preferred option for NSW for the following reasons:

* In common with option 5 it is the only option which provides protection for the health of both employees and patrons from ETS exposure;

* It provides simplicity in terms of operation particularly compared to option 5 where it is difficult to harmonise penalties under the OHS Act and the Public Health Act;

* It provides for equal treatment of all sectors of the hospitality industry;

* It avoids the need for expensive ventilation equipment;

* It addresses the public's call for government action to address ETS exposure in this industry.

As well, this option clarifies the legal responsibilities of the hospitality industry operators which would bring them in line with other workplaces. It clarifies the uncertainty of operators in terms of their legal position and avoids the potential for future increases in legal costs associated with passive smoking prosecutions.

The majority of the Taskforce was of the view that the initial implementation costs for this option were justified in the light of the public health benefit and the protection offered to employees from the risks of ETS. It is expected that litigation costs would be minimised under this option because it effectively eliminates future employee exposure to ETS leaving only cases of past exposure to be dealt with by the courts. The Taskforce noted that the economic analysis in the Shiell report was not able to take account of the effect of the options on litigation costs and came to the conclusion that these litigation costs would be significant under options 1 and 2.

The majority of the Taskforce felt that the preferences of smokers could be provided by allowing smoking in outdoor areas such as courtyards, beer gardens, verandahs etc.

The majority of the Taskforce also concluded from the evidence it considered that there were no public health grounds to treat eating and drinking facilities differently. The Taskforce therefore considered recommendations across the hospitality industry as a whole to ensure adequate health protection for all employees and patrons and to avoid giving particular segments of the industry economic advantages compared to other segments. For this reason, recommendations for the separation of eating and drinking facilities as well as those internal to the establishment (which was found to be a characteristic of some international legislative action) have not been provided by the Taskforce. The substantial differences between segments of the industry were acknowledged.

The Taskforce also noted the experience of the ACT which has implemented similar legislation successfully to date in restaurants and the recent announcements of the South Australian government to introduce legislation banning smoking in indoor eating areas from 1 January 1999.

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SECTION 10

IMPLEMENTATION AND DISCUSSION OF TASKFORCE'S RECOMMENDATION

The following implementation plan has been developed in support of the Taskforce's recommendation of Option 3. This plan identifies issues and key stakeholders that are critical to the implementation of this option. The Taskforce considers that it is important that the proposed legislation is introduced and operating before the commencement of the 2000 Olympics. It is therefore recommended that the implementation date would be 1st March 1999. This also provides adequate time for venues to make any physical changes if necessary to their establishments (such as accommodating smokers in outdoor areas) and to make applications regarding their liquor licenses if required.

Key Implementation Issues

The four key elements of the implementation plan are :

1. Legislative and Education Activities

These include:

(1) Development and enactment of legislation which would ban smoking in indoor places where food and beverages are consumed;

(2) Development and implementation of a public education strategy to precede the commencement of the legislation;

(3) Development and implementation of an education strategy for the hospitality industry and enforcement agencies;

(4) Monitoring and enforcement of the new legislative changes.

The key stakeholders identified by the Taskforce in the implementation process include the following groups:

NSW Health;
NSW Quit Campaign;
Non-government organisations;
Health workers;
The Hospitality industry;
WorkCover Authority of NSW;
Environmental Health Officers;
Food Inspectors;
Local Government Officers;
Police;
Unions; and
General Community

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1. Develop and Enact Legislation to ban smoking in indoor places where food and beverages are consumed.

The legislation will define the places where the legislation applies, and will require placement of appropriate signage, designate the enforcement bodies for the Act and the penalties for breaches of the Act.

Smoking in a prohibited area will be an offence and the Act should also specify the steps to be taken by the occupier to prevent smoking in that area.

1.2. Public Education Strategy

The public education program will target the community and will be designed to support three primary objectives:

Increase the community's knowledge about the health risks of passive smoking;
Increase the community's knowledge about the new legislation;
Mobilise community support for the legislation

This strategy will support the need identified by The Tobacco and Health Strategy to implement public education campaigns to increase the community's knowledge of the health risks associated with passive smoking.

The NSW Health Promotion Survey (1994) indicates that widespread public support already exists for smoking restrictions in public places such as restaurants and hotels. The public education strategy will work towards enlisting further public support for the legislative changes recommended by the Taskforce, as well as increase the willingness and capacity of the community to take action on the issue and ensure that the community is aware that the regulations are being enforced.

The public education program would include a marketing communication strategy which would involve the development and placement of media/advertising materials, the promotion of a community telephone info-line, the development of information and promotional resources.

Key agencies involved in the public education strategy include NSW Health Department, NSW Quit Campaign, NSW Cancer Council, National Heart Foundation and health workers from these bodies operating in the local community.

1.3. Education strategy for the Hospitality Industry and Enforcement Agencies

The Taskforce has identified the need for specific education and training programs which target the hospitality industry's workforce, health workers throughout NSW, and the enforcement agencies identified by the legislation.

The training and education programs will assist by:

(I) Increasing the hospitality industry's understanding of the new legislation and compliance issues,

(ii) Increasing the enforcement agencies' understanding of the legislation and

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compliance issues.

(iii) Increasing the willingness and capacity of local health workers to work with the hospitality industry in developing local projects.

The implementation of the education strategy for the hospitality industry and enforcement agencies will require the involvement of all segments of the hospitality industry, NSW Health Department, WorkCover Authority of NSW, NSW Quit Campaign, local government, NSW Cancer Council, National Heart Foundation, and relevant unions.

1.4. Monitoring and Enforcement of the Legislation

Experience in the ACT and internationally has shown that education, information and appropriate signage are usually sufficient to ensure compliance with legislation prohibiting smoking. The compliance with the legislation is partially dependent on there being an effective education and training campaign (Kagan and Skolnick, 1993). The need for formal enforcement is therefore minimised when both the public and the hospitality industry are fully aware of the requirements of the legislation and the penalties for non compliance.

A range of health and local government workers are currently responsible for inspecting, monitoring compliance and enforcing public health legislation in the hospitality industry. These include Health Promotion Officers, Environmental Health officers, and Food Inspectors in the Public Health Units and those attached to local councils.

The WorkCover Authority of NSW has also been identified as an important agency for the enforcement of new legislation which prohibits smoking at hospitality establishments. Inspectors are assigned to investigate complaints from workplaces regarding smoking policies including environmental tobacco smoke exposure issues.

2. Timeframe

The timeframe for the implementation of these elements is presented in Table 11. It can be seen from this table, that some strategies would be developed and implemented concurrently, some would be implemented at different times and there would be specific strategies such as education, enforcement and monitoring which would be ongoing but at different levels of activity.

3. Program Costings

The following costs have been identified in relation to the implementation program recommended by the Taskforce:

Public Education Program

The cost for the public education program is estimated to be $1,000,000 over a two-year period. The current allocation for the NSW Quit Campaign for mass media activities is $600,000.

Costs associated with the activities undertaken by the non-government agencies such

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

as the NSW Cancer Council and the National Heart Foundation are not included in these costs.

Hotline Services

The establishment of a telephone hotline to take public complaints is expected to require one full-time staff member for up to one year. The total cost for this component is $45,520.

Enforcement and Monitoring

An allocation is required for additional personnel (Environmental Health Officers) to be allocated to each of the Public Health Units to undertake local monitoring and surveillance activities in the hospitality industry. As well, co-ordination of enforcement would be undertaken by a full time policy officer for a three-year period. Therefore, enforcement and monitoring over a three -year period would total $1,584,000.

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Table 11: Time frame for Implementation Program for Option Three

Year	Month	IMPLEMENTATION PROGRAM ACTIVITIES						
		T/F Report	*Legislation*	*Mass Media Activities*	*Training Health & Enforcement*	*Training Industry*	*Enforcement*	*NGO's*
1997	March							
	April							
	May							
	June							
	July							
	August							
	September							
	October							
	November							
	December							
1998	January							
	February							
	March							
	April							
	May							
	June							
	July							
	August							
	September							
	October							
	November							
	December							
1999	January							
	February							
	March							
	April							
	May							
	June							
	July							
	August							
	September							
	October							
	November							
	December							
2000	January							
	February (ongoing)							

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

SECTION 11

ISSUES AND INITIATIVES RECOMMENDED FOR A NATIONAL APPROACH

In the process of considering evidence, current issues and strategies for the development of the Taskforce's report, issues arose which have been recommended by the Taskforce for further investigation and action through existing national bodies. These issues are:

(i) To consider addressing the problems of eliminating the health risks of ETS exposure through an examination of the technical capacity of ventilation systems by the review body of the Australian Standard; and

(ii) To continue exploration and validation of the health evidence relating to passive smoking and the risks to all members of the community from exposure in the following situations:

- Enclosed workplaces and public places; and
- Outdoor areas

(i) Air Conditioning Standard

Ventilation requirements in Australia are set out in the Standard, AS 1668.2. The Standard was established on the basis of acceptable odour levels and is not a health-based Standard. It is understood that this Standard is currently under review. The Standard has determined acceptable outdoor air rates for various occupancy types such as bars, cocktail lounges, dining rooms, fast food outlets and food preparation and storage areas. For an enclosure in which an excess of ETS is anticipated, it is recommended that outdoor air quantities should be increased to an appropriate value. All values of outdoor air tabulated or calculated are minimum values.

To attain a health-based standard which would address the ETS particulate phase and to therefore reduce carcinogenic risk to non-smokers the Taskforce is advised would result in extremely high air flow rates which are impractical in real world applications.[133]

A reduction in outdoor air rates is permitted if particulate air filters for air cleaning are installed in the air handling plant. Important factors for these systems to be effective are:

. The quantity of recycled air treated in the plant.

. The efficiency of the air cleaning device.

Currently, determining the efficiency of the air cleaning device in terms of testing the gas phase cleaning does not exists. Filters used in general air conditioning applications have not been tested to particles below 0.2 microns. ETS has a significant number of particles below 0.2 microns. Therefore, the efficiency of these filters to remove ETS particulates is unknown. As well efficiency diminishes with time and the devices usually need regular servicing.[134]

The Taskforce therefore recommends that as part of the current review of the

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Australian Standard AS 1668.2, the ability of existing ventilation systems, the determination of outdoor air rates and the efficiency of air filters should be explored further in terms of addressing the problems these systems and mechanisms have in eliminating the health risks of ETS exposure.

(ii) Health Evidence Relating to ETS Exposure

Throughout its deliberations the Taskforce has been mindful of the need for a commitment for ongoing examination of new and emerging evidence relating to passive smoking. The Taskforce recognises that the health effects of passive smoking have been the subject of many scientific studies and reviews by major health authorities particularly since the late 1970's. The terms of reference of the Taskforce did not allow the Taskforce to undertake a comprehensive evaluation of the scientific and medical evidence. The Taskforce believes that this task is more appropriately the responsibility of other working parties such as the national body NHMRC which are specifically convened for this purpose.

The Taskforce identified the following areas which are particularly central to the issue of passive smoking:

- **Public and Employees Exposures in the Workplace and Enclosed Public Places.**

Studies of the health effects of passive smoking have used domestic exposures as the basis of their assessments. The United States Environmental Protection Agency has stated in its report that exposure levels of ETS in the workplace are generally comparable with exposure level in the home.[135]

The Taskforce recommends that further investigations are made which directly explore the effects of ETS exposure on the general community and employees in enclosed workplaces and public places.

- **Exposure to ETS in Outdoor Areas.**

The Taskforce received advice from Scientific Services Branch of WorkCover Authority of NSW which stated that exposure to ETS in outdoor areas may be a health risk in some circumstances. The risk is dependent upon the dilution factor of the air available. Factors such as variable wind velocity and direction and lack of wind shelters or barriers assist in the dilution process.[136]

The Taskforce recommends that further investigations are made into the risks to health of ETS exposure in outdoor areas and the identification strategies which can assist in reducing these risks.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

ATTACHMENT I

MEMBERSHIP OF THE PASSIVE SMOKING TASKFORCE

Dr Andrew Penman (Chair)
Director
Disease Prevention and Health Promotion

Mr Stephen Banister
The Registered Clubs Association of New South Wales

Associate Professor Simon Chapman
National Health and Medical Research Council (NHMRC)

Mr David Charles
Australian Hotels Association (NSW)

Dr Chris Clarke
Australian Medical Association (NSW)

Mr Peter Harley
NSW WorkCover Authority

Ms Anne Jones
Action on Smoking and Health (ASH Australia)

Ms Jenny Lambert
Restaurant & Catering Association

Ms Jeanie Mckenzie
NSW Cancer Council

Ms Kate Purcell
(representing the Director)
Drug and Alcohol Directorate
NSW Department of Health

Ms Sheila Walker
National Heart Foundation

Mr Andrew Wilson
(representing the Director)
Legal Branch
NSW Department of Health

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

ATTACHMENT II

CURRENT LEGISLATION IN NEW SOUTH WALES

Passenger Transport Act 1990 - Regulation

(Passenger Transport (Ferry Services) Regulation 1995.
Smoking, eating and drinking on ferries

17. (1) A person must not smoke on any ferry or part of a ferry on which smoking is prohibited by signs displayed on the ferry or part, except with the written permission of the ferry operator.

Maximum penalty: 5 penalty units.

(Passenger Transport (Private Hire Vehicle Services) Regulation 1995)
Behaviour of drivers

15. The driver of a private hire vehicle must not do any of the following:
(a) smoke while the vehicle is conveying any passengers;
(b).....
(c).....

Smoking

22. A person must not smoke tobacco or any other substance in any private hire vehicle in which smoking is prohibited by signs displayed in the vehicle.

Maximum penalty: 2 penalty units

(Passenger Transport (Bus Services) Regulation 1995)
Smoking, eating and drinking

30. (1) A person must not smoke in any bus or part of a bus in which smoking is prohibited by signs displayed in the bus or part, except with the written permission of the bus operator.

Maximum penalty: 5 penalty units.

Theatres and Public Halls Act (General) Regulation, 1977.
Smoking

73. (1) Subject to subclauses (2) and (3) , no person shall smoke in the auditorium, projection suite, stage area or wings, or in a plant room, storeroom or property room in a theatre or public hall.

(2) Where a function conducted in a theatre or public hall -
(a) is a public meeting;
(b) is a function at which meals or liquor are served;
(c) is an entertainment of an approved type;
(d) is a private entertainment; or
(e) consists of dancing,
smoking may be permitted in the auditorium provided smoking has been authorised in writing by the holder of the license in respect of that theatre or public hall.

(3) Where necessary in conjunction with a performance being conducted in a theatre or public hall, smoking by performers may be permitted -
(a) on the stage; or
(b) in the auditorium.

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Inclosed Lands Protection Act 1901 No. 33

The Inclosed Lands Protection Act, 1901 (NSW) creates an offence for any person who, without lawful excuse, remains upon the inclosed lands of another person after being requested by the owner or a person apparently in charge of those lands (or part of a building) to leave those lands (s.4(1)). It also creates an offence where a person, while remaining upon inclosed lands, behaves in an offensive manner (s.4A).

These provisions could be used to enforce smoking restrictions on private property such as offices, shopping centres, restaurants, clubs and the like. (This Act is currently being used by some shopping centres to assist them to enforce their smoke free policy.) It is important that the request to leave be made by the owner or a person apparently in charge of the property. Charges may be laid privately or by the police. If police co-operation is required, it may be appropriate to inform the officer in charge of the nearest police station that assistance may be required to enforce this legislation if it is anticipated that any difficulty may be experienced.

Construction Safety Regulation, 1950
Smoking prohibited in lifts.

72. (1) A person shall not-
(a) smoke any substance or any cigar, cigarette, pipe or other smoking implement; or
(b) carry a lighted cigar, cigarette, pipe or other lighted smoking implement, in the car of a passenger lift, other than a passenger lift used in a single unit dwelling house.

(2) A person who commits a breach of paragraph (1) shall be liable to a penalty not exceeding 1 penalty unit.

Nursing Homes Act 1988
Nursing Homes Regulation 1996.

33 Smoking
(1) A nursing home must have a written policy on smoking by residents and staff.
(2) The nursing home policy in relation to smoking must provide:
(a) that neither residents nor staff are allowed to smoke in wards or dining areas, and
(b) that, if residents or staff are allowed to smoke within the nursing home smoking is to be confined to designated areas that allow other residents to avoid exposure to smoke without unduly restricting their activities,
(c).....

Private Hospitals Regulation 1996

29 Smoking
(1) There must be a written policy on smoking in the private hospital by patients and staff.
(2) The policy on smoking must provide:
(a) that neither patient nor staff are allowed to smoke in wards or dining areas, and
(b) that, if patients or staff are allowed to smoke within the private hospital, smoking is confined to designated areas that allow other patients to avoid exposure to smoke without unduly restricting their activities, and
(c).....

Day Procedure Centres Regulation 1996.

16 Smoking
(1) There must be a written policy on smoking in the day procedure centre by patients and staff.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

(2) The policy on smoking must provide that, if patients or staff are allowed to smoke within the day procedure centre, smoking is confined to designated areas that allow other patients to avoid exposure to smoke without unduly restricting their activities.

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enacted laws that restricted smoking in public places. In 1992, 45 states and the District of Columbia restrict smoking in some manner. At the local level, approximately 90 communities restricted smoking in public places in 1985 and by 1990, over 480 counties or cities in 34 states had enacted anti-smoking ordinances, some of which are more stringent than the corresponding state laws (Tobacco Free America 1990).

There are currently over 50 municipalities which have ordinances in place banning smoking in restaurants including New York, Los Angeles, and Aspen, Colorado. States which prohibit smoking in restaurants include California and Vermont.

Only a few states have enacted comprehensive clean indoor air laws that restrict smoking in a wide range of public places. (Tobacco Free America 1990), despite 80-85% of the public favouring restrictions on smoking in public places (Gallup Poll (1985 and 1990).[6]

Comparison of State Anti-Smoking Laws

Throughout the USA, there are variations on the level of state anti-smoking legislation and its effectiveness in terms of actual provisions. This can be explained by the variation in the level of local ordinances within each state. New York for example has extensive local ordinances that cover nearly 60% of the state's population, Florida and Illinois have statewide legislation preempting more stringent local ordinances. Neither Arizona nor Texas has enacted statewide smoking restrictions, though Arizona does have stronger local ordinances than Texas.[7]

The following provides details of statewide legislation in six states of the US.[8]

1. New York State

The Clean Indoor Air Act of 1989 requires nonsmoking areas in workplaces, restaurants and public places such as auditoriums, theatres, schools, and public transport.

Restaurants, cafeterias, coffee shops and cafes with 51 seats or more must provide nonsmoking areas large enough to meet customer demand. A restaurant can set aside separate rooms for smokers and nonsmokers, but it is not required to do so. A food service establishment may choose to become totally 'smoke-free' although 70% nonsmoking is the maximum that can be required under State law.

The Act does not apply to food services establishments with 50 or fewer seats. Smoking is permitted in bars and is permitted in bar areas only of restaurants. Enforcement of this Act is the responsibility of counties' Board of Health or a designated enforcement officer if a county has no Board of Health.

Proof of financial hardship is a basis for an application for exemption.
One of its features is that the bill gives enforcement powers to local governments, and because the law does not include a preemption provision, localities are free to enact more stringent regulations.

New York has some of the strongest local anti-smoking ordinances in the nation. Between 60% and 70 % of the public is covered by stringent local anti-smoking ordinances including restrictions of smoking in a wide range of public places, bans on placement of tobacco advertising and bans on cigarette vending machines accessible to minors. Many of these local ordinances were in place before the introduction of the Clean Indoor Air Act.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

2. Minnesota

In 1975, Minnesota passed the nation's first comprehensive Clean Indoor Air Act and since then has been in the forefront of anti-smoking legislative initiatives. The 1975 law banned smoking in a wide range of public places - including restaurants, retail stores, public facilities, and conveyances, worksites, hospitals and health care facilities - except in designated areas. In 1985, the Minnesota legislature passed the Omnibus Nonsmoking and Disease Prevention Act, which contained a number of provisions that both strengthened and extended the 1975 law. Specifically the 1985 law provided funding for smoking intervention programs for youths, public education and communications campaigns, and special project grants to community health services. It provided funds to the State Department of Health to engage in smoking prevention issues and to implement the provisions of the bill.

Few initiatives by local governments to further apply restrictions of smoking in public places by the implementation of local ordinances have developed owing to the domination of the statewide legislation and the ongoing efforts to strengthen and expand the legislation.

3. Florida

Florida enacted its Clean Indoor Air Act in 1985. The act restricts smoking in public places or at public meetings, except in designated smoking areas. This prohibition does not apply when an entire room or hall is used for a private function. Additionally, local governing bodies are prohibited from enacting ordinances more stringent than this legislation (that is, local legislation is preempted by provisions of the Clean Indoor Air Act). In restaurants or bars with more than 50 seats, the law requires a designated smoking section or post a sign that reads, "We have no non-smoking section".

4. Illinois

Under the 1989 Clean Indoor Air Act, smoking is restricted in arts/cultural facilities, elevators, gymnasiums, public places, public transport, restaurants and other places. The Law does not restrict smoking in bars, bowling alleys, hotel rooms. The law requires no smoking at all unless a smoking area is set up. The legislation allows business owners to designate a 'reasonable portion' of a room as a smoking area, but the size of this 'reasonable portion' is not defined. The act preempts local communities from enacting policies more stringent than those of the state law. Also the law includes a provision prohibiting discrimination on the basis of smoking behaviour.

5. Arizona

Arizona was, in 1973, the first state to pass a law that restricted smoking in a variety of public places to designated areas. No subsequent statewide legislation of significance has been passed. There has however been widespread adoption of local ordinances in 14 cities and counties, which mostly requires that nonsmoking areas be designated in enclosed public areas and enclosed common areas at worksites (e.g. conference rooms and rest rooms). The 1973 law prohibits smoking in elevators, public restaurants, buses and a range of other public places, except in designated areas.

6. Texas

Existing law requires that smoking be prohibited in a half dozen or so public places - including public transport, elevators, health facilities, libraries, museums, theatres and schools except in designated areas. It does not include restaurants. Many of localities have passed ordinances that substantially restrict smoking in public places. 88 of Texas's 200 largest cities have passed one or more local anti-smoking ordinances.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

7. Alaska[9]

Information regarding smoke free legislation for Alaska has been obtained from the internet and the web site has been provided as the reference.

Alaska statutes:
Title 18. Health, Safety and Housing
Chapter 35. Public Accommodation and Facilities
Article 3. Regulation of Smoking in Public Facilities
Section 300. Places where Smoking is Regulated.

Smoking in any form is prohibited in the following vehicles and indoor places, except as allowed under AS 18.35.310:

> (7) a food service establishment that has a seating capacity of at least 50 persons;

AS 18.35.320. Designation of Smoking Sections.

> (c) A person who designates a smoking section under this section shall make reasonable accommodation to protect the health of the nonsmokers who use the place or vehicle by separation, partition, or ventilation that ensures that nonsmokers in the place or vehicle are not subject to the active by-products of smoke from smokers in the place or the vehicle.

AS 18.35.350. Enforcement Authority.
The commissioner or the commissioner's designee is responsible for enforcing the provisions of AS 18.35.300 - 18.35.365.

Legislation and Local Ordinances in place in the US

The following Californian examples of variations in local ordinances and legislation are presented:

San Francisco

Article 19E Municipal Code (Health Code): Prohibiting Smoking In Places of Employment and Certain Sports Arenas. sec. 1009.5

> (a) No employer shall knowingly or intentionally permit, and no person shall engage in the smoking of tobacco products in an enclosed space at a place of employment.

This ordinance provides for smoke free dining in restaurants, and exemptions are provided for bar areas, 25% of lobby areas, 65% of guest rooms. Employers may apply for exemption on the grounds of hardship caused by compliance with this Article.

Enforcement is undertaken by the Director of Public Health by the serving of notices requiring the correction of any violation within a reasonable time.

Sacramento

Chapter 37 Clean Indoor Air and Health Protection Ordinance.
Section 37.04 Smoking Prohibition, Public Places.
It is unlawful for any member of the General Public including an employee to smoke in the Public Places named and described in section 37.05 through 37.19.

37.13 Restaurants

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Within all restaurants, the prohibitions contained in Section 37.04 shall be applicable to lobbies, waiting areas, restrooms, and those dining areas which are designated as nonsmoking. Enclosed bar areas are exempt from this ordinance.

Novato
Clean Indoor Air and Youth Health Protection Ordinance.
Smoking is prohibited in a range of public places including restaurants. Bars are exempt where the establishment does not permit smoke to filter into a restaurant through a passageway, ventilation system or other means.

Smoking is permitted in restaurants being used for private purposes but only where a separate ventilation system is in place. However, 50% of these areas will be designated smoke free.

This ordinance is the responsibility of County Health Inspectors, and a private citizen may bring legal action to enforce this Section.

Belvedere
Ordinance No. 93-1
Prohibiting Tobacco Smoking in Public Places and Places of Employment and Regulating the Sale of Tobacco Products.

Smoking is prohibited in all enclosed public places including restaurants except where cocktail lounge areas within restaurants have a separate ventilation system and is enclosed, in bar areas where smoke cannot filter into a restaurant through a passageway, ventilation system or other means, and in 1/2 of adjoining outdoor food areas when clearly posted.

San Buenaventura
Ordinance No. 94-01
Article 7 - Smoking regulated or Prohibited Sec. 6270.
Smoking is prohibited in restaurants both indoor and outdoor except where dining rooms are being used for private purposes provided these rooms are equipped with separate ventilation systems. However, 50 % of these areas shall be designated nonsmoking. Bar areas within restaurants are exempt provided that smoke cannot filter into a restaurant eating area through a passageway, ventilation system or other means.

San Luis Obispo
Ordinance No. 1172 bans smoking in all restaurants and bars in the City.

4. Canada[10]

In Canada, the municipalities which have passed legislation to prohibit smoking in restaurants include Vaughan, Vancouver, Guelph, Windsor and London.

There is a commitment by the Medical Officers of Health in Metropolitan Toronto, to work together to achieve the common goal of 100% smoke free public places in all Metropolitan municipalities, This initiative to ban smoking in public places including restaurants is also being considered by several municipalities/regions beyond the Metropolitan Toronto boundaries including Halton region, York region, and Durham Region.[11]

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

The following are some examples of Canadian municipalities which have initiated specific bylaws regarding smoke free legislation.

Toronto

Smoking is currently permitted in up to 50% of a restaurant seating area. In 1996, City Council passes a by-law (July 2, 1996), banning smoking in all eating establishments, including restaurants and bars. The by-law comes into effect January 1, 1997.[12]

Vancouver

Vancouver's Smoke Free Indoor Air Bylaw takes effect Friday, May 31, 1996. Smoking is prohibited in all places of employment and in all indoor public places where minors have access. This includes all restaurants and mall food fairs. Adult-only establishments may designate a maximum 70% of all their seating capacity as a smoking area.

Active enforcement will not commence until December, 1 1996, to allow for public education.[13]

British Columbia

Under the Clean Air Bylaw:

Smoking is prohibited in all parts of all buildings, except in:

1. Private residences, and
2. designated smoking areas.

Smoking is prohibited in workplaces, educational institutions, and public premises other than in designated smoking areas.

Designated smoking areas are only permitted in the following places, and subject to conditions concerning ventilation, size and location:

* extended care and long term care facilities
* restaurants
* licensed premises
* bowling alleys
* bingo halls
* casinos

Unless the owner or operator of any of the following businesses designates the entire business premises as non-smoking, the following restrictions apply.

1. Restaurants

The designated smoking area cannot be greater than 40% of the seating areas.

2. Bowling Alleys

The designated smoking area must be located in an observation area which is not adjacent to the bowling lanes and cannot be greater than 50% of the observation area.

3. Bingo Halls

The designated smoking area cannot be greater than 60% of the seating area.

4. Extended and Long Term Care Facilities

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

The designated smoking area must be ventilated away from the rest of the facility and may be used by patients or residents only.

Places which are completely smoke-free include:

1. Workplaces.

2. Some types of public premises including but not limited to, places of public assembly, personal service establishments, reception areas, elevators, escalators, stairwells, corridors, lobbies of public premises, hotels, office buildings and offices, retail stores, shopping malls, hospitals, financial institutions, laundromats, bus shelters and public washrooms.

3. Places of public assembly including but not limited to, theatres, convention centres,(except separate smoking lounges nor used for general purposes), arenas, recreation centres, training centres, video arcades, pool and billiard halls, dance halls, church halls, concert halls, auditoriums, swimming pools, movie houses, lecture halls, museums and art galleries.

4. Personal service establishments including, but not limited to, hairdressers, barber shops, beauty parlours, health spas, tanning salons, and gymnasiums. massage parlours, tattoo shops, saunas and steam baths.

Enforcement

A person who contravenes the Bylaw will be liable to a fine of between $25.00 and $500.00 for the first offence, and a fine of up to $2000.00 for the third or subsequent offence.[14]

Greater Victoria

The Capital Regional District is imposing a smoking ban as of Jan, 1, 1999. It will apply to anything burning tobacco and will cover all indoor places other than private homes or vehicles. The ban includes pubs, nightclubs, private clubs and bingo halls.Businesses will have to post no smoking signs.

The penalties includes fines for the first offence of between $100 to $500; second offence $200 and $1000; and third offence $300 and $2000.[15]

5. Countries Of The European Economic Community (EEC)

The following information on legislative initiatives aimed at eliminating and/or restricting smoking in public places in countries of the EEC has been taken from the report, "Comparative Study of Anti-Smoking Legislation in Countries of the European Economic Community" prepared by Sasco A.J., Dalla-Vorgia, P., Van der Elst, P. (1992) for the International Agency for Research on Cancer (IARC Technical Report No.8). This document examines both existing and proposed legislation and regulations involving tobacco use. The information contained in the report was partly provided by the governments of the member states of the Commission of European Communities, and also from reference works on anti-smoking legislation.

Belgium

The Crown Order of 31 March 1987 (Crown Order prohibiting smoking in certain public places) defines precisely areas where smoking is prohibited. This list includes health

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facilities for the aged and young, educational facilities, personal hygiene areas, public service buildings, theatres, cinemas and sports centre.

Section 3 states that certain areas can be designated for smokers, and grants the authorisation for smoking areas in restaurants, except in schools and health-care establishments.

The Crown Order of 15 May 1990, which repealed the above Crown Order, gave more precise instructions on the allocation of space to non-smokers with emphasis on the need to protect their health. At least 1/3 of available space (to be extended to 1/2 by 31 December, 1992) should be reserved for non-smokers. Non-smoking areas should be properly marked. In addition in places such as restaurants where both smokers and non-smokers are present, smoke extractors and ventilation systems must be installed.

The Crown Order of 2 January, 1992, subsequently specified that ventilation systems were to be installed at the anticipated date of 1 May, 1991.

Denmark

The first restriction to smoking in public places was a Directive of 1979 from the Ministry of Health and the Interior concerning smoking in hospitals. Section 2 of the Bill of 29 October 1987 (law concerning the provision of smoke-free environments and the labelling of tobacco products) ensures that both smokers and non-smokers have a smoke-free environment. Section 2 makes it compulsory for all public institutions to establish smoking regulations which protect the public from passive smoking. It is compulsory to provide smoking and non-smoking areas in restaurants and on public transport. The Minister for Health has also called upon the individual municipalities and countries to implement similar rules.

France

Section 16 of Title 2 of the Law of 9 July, 1976 (law concerning measures to combat smoking) states that the Council of State will determine by decrees the conditions under which smoking prohibitions will be established in places for public use where smoking could have dangerous health consequences. It states that on transport or in places with smoking and non-smoking areas, the area reserved for non-smokers cannot be less than 50% of the whole area.

The decree of 12 September, 1977 (decree prohibiting smoking in certain places intended for use by groups of people where this practice may have harmful effects upon health) lists in detail the places where smoking is prohibited. Section 1 specifies that smoking is prohibited in public places which do not conform to ventilation standards.

Smoking is also prohibited in places where food is stored, handled, or prepared but not where food is served.

Germany

Smoking in public places is controlled by the municipal authority. There is no existing regulation on smoking in the workplace, except for rules governing adequate ventilation.

Greece

There are restrictions on smoking in public places , such as cinemas or theatres, public or private hospitals, private nursing homes and on public transport.

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

Ireland

The Tobacco (Health Promotion and Protection) Act, 1988 prohibits and /or regulates the use of tobacco products in designated areas or specific places, including transport, health care premises, schools, public service buildings, cinemas, theatres, but not restaurants or bars and bar areas.

Italy

Section 1 of the Law of 11 November 1975 (law prohibiting smoking in specified premises and on means of public transport) lists areas where smoking is prohibited: hospitals, schools, public transport, enclosed areas for public meetings, cinemas, theatres.

The Ministerial Decree of 18 May 1976 (Ministerial Decree laying down provisions governing air-conditioning or ventilation systems) lays down technical conditions for air-conditioning or ventilation systems as required. Failure to function or to keep air temperature and humidity within prescribed limits must cause illuminated "No smoking" signs to switch on automatically at clearly visible points.

Luxembourg

The Law of 24 March 1989 (Law restricting the advertising to tobacco and tobacco products and prohibiting smoking in certain places) is intended to restrict smoking in hospitals, health services, clinics, sports halls, cinemas, theatres and galleries. There are no restrictions regarding restaurants or bar and bars areas.

The Netherlands

The Law of 10 March 1988 (Law prescribing measures for the restriction of tobacco use and, in particular, for the protection of non-smokers (the Tobacco Law) addresses smoke free workplaces, the sale of tobacco products in certain venues and institutions, and supplementary measures covering health, social, sport and educational facilities.

Portugal

The decree of 8 November 1988 extended the Law of 17 August 1982 (on the control of smoking) to permit restaurants to establish smoke-free areas. It also states that measures have to be taken to protect non-smokers at the workplace.

The Decree-Law of 30 August 1989 broadens the definition of restaurants to include places such as cafeterias, coffee houses, etc and permission is given to managers to designate certain areas within their establishments as smoke-free.

Spain

The Crown decree of 4 March 1988 (Crown Decree laying down restrictions on the sale of tobacco, for the protection of the health of the population) in Section 1 declares tobacco to be harmful to health and consequently where there is a conflict of rights, the rights of non-smokers to health prevails over the right of smokers to consume tobacco in all places or circumstances in which the right of the former to health may be adversely affected.

No specific mention is made of restaurants or bars and bar areas. The Decree targets schools, public transport, health institutions, places where pregnant women work, public administration centres, halls, enclosed commercial premises, theatres, cinemas, sports centres and lifts (with the provision that marked smoking areas be established in some of these places such as theatres, waiting rooms, enclosed public premises and health

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centre).

The United Kingdom

In the United Kingdom, a system of self-regulation applies in relation to smoke-free policies and workplaces. A report on a review by government of the provision of smoke-free indoor environments in businesses that deal with the public was released in 1992. This report made recommendations for the establishment of smoking policies by these businesses. A follow-up survey conducted in 1996 found that 36% of restaurants had established 'effective policies'.[16]

Norway

Regulations No 563 of 8 July 1988 encourage the gradual introduction of non-smoking environments in common areas of restaurants and hotels and urges that new constructions take account of this factor. The goal is that within five years of the entry into force of the regulations, not less than 1/3 of the tables, seating accommodation, and rooms shall be non-smoking and that common areas shall also be non-smoking.[17]

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

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ATTACHMENT IV

VENTILATION ISSUES AND RISK FROM EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (ETS)

- Report by Clive Broadbent and Stan Wesley

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Source: https://www.industrydocuments.ucsf.edu/docs/tzyk0000

VENTILATION ISSUES AND RISK FROM EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE (ETS)

Report by

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Commissioned by the
NSW Passive Smoking Taskforce
through the
WorkCover Authority
August 1996

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PREFACE

The Report was commissioned by the NSW Passive Smoking Taskforce through the WorkCover Authority NSW. The investigation set out to examine the role of ventilation in relation to ETS, particularly whether ventilation is able to avoid adverse health effects arising from ETS in restaurants, clubs and the like.

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CONTENTS

PREFACE	**2**
SUMMARY AND CONCLUSION	**5**
RECOMMENDATIONS	**6**
SECTION 1 INTRODUCTION TO VENTILATION STANDARDS	**7**
1.1 Indoor Air Quality	7
1.2 Health and Comfort	7
1.3 Other Current Standards	8
1.4 Governmental Approaches	9
1.5 The Ontario Government's Standards	9
1.6 Further Comment	9
SECTION 2 PRACTICAL APPLICATION OF AS 1668.2	**11**
2.1 The Standard	11
2.2 Ventilation Concessions for Air Filters	12
2.3 Filter Performance Calculations	12
2.4 Air Filters and Air Quality	12
2.5 Dilution Ventilation of Contaminants	13
2.6 Local Exhausts	15
2.7 Air Distribution	15
2.8 Health Effects	15
2.9 Further Comment	16
SECTION 3 VENTILATION AND SMOKE-FREE LEGISLATION IN THE ACT	**17**
3.1 The Act	17
3.2 Restaurants	17
3.3 Report Form	17
3.4 Licensed Premises	18
3.5 Further Comment	18
SECTION 4 THE EXPOSURE RISK	**20**
4.1 Risk Evaluation	20
4.2 The BRE Methodology	21
4.3 Nature of the ETS Health Hazard	22
4.4 Methods of Reducing ETS Exposure	23
4.5 Effect of Ventilation in Reducing Risk	24
4.6 Use of Air Cleaning to Reduce Risk	26
4.7 Effectiveness of Smoker - Non-smoker Separation	27
4.8 Further Comment	30
SECTION 5 MEASURES TO REDUCE RISK	**31**
5.1 Options	31
5.2 Common Courtesy	31
5.3 Voluntary Policies	31
5.4 Separate Smoking and Non-smoking Sections	32
5.5 Segregation with Ventilation/Filtration	32
5.6 Separate Smoking and Non-smoking Environments	33
5.7 Legislated 100% Smoke-free Restaurants/Clubs, etc	34

2063652774

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5.8 Further Comment 34

SECTION 6 COSTS OF IMPROVEMENTS 35

6.1 Applications 35
6.2 Case study - Restaurant 35
6.3 Case study - Hotel 35
6.4 Case study - Functions Bar at Hotel 35
6.5 Case study - Club Poker Machine Area (Casino) 35
6.6 Case study - Restaurant 36
6.7 Further Comment 36

SECTION 7 PRACTICALITY OF MONITORING ETS 37

7.1 Problems of Monitoring 37
7.2 Cost of Monitoring 37
7.3 Further Comment 38

SECTION 8 REFERENCES 39

APPENDIX 1 42

APPENDIX 2 46

1 Sample Calculation - Office 46
2 Sample Calculation - Conference Room 47

APPENDIX 3 48

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SUMMARY AND CONCLUSION

Because environmental tobacco smoke (ETS) is so ubiquitous and has so many serious adverse health effects, it is considered by authorities to be the single most important indoor air contaminant.

In the hospitality industry, employees are the most at risk.

ETS comes from smoking tobacco and is therefore not a part of building design or operation. Exposure is related primarily to the behaviour of occupants but can be modified by ventilation strategies.

Natural ventilation tends to be inadequate leaving some areas within buildings poorly ventilated. Natural ventilation (and mechanical ventilation at times) can result in smoke moving from smoking rooms into the rest of the building unless there is good sealing of internal doors. Removal of ETS by mechanical ventilation for comfort control is slow unless there is a high fresh air supply and no recirculation. Filters used in general ventilation applications are inefficient or ineffective at removing tobacco smoke particles (the gaseous phase is not filtered at all).

Ventilation requirements in Australia are set out in AS 1668.2. As with all ventilation codes, standards were established on the basis of acceptable odour levels for various building occupancies. AS 1668.2 is a design standard arrived at by a process of consensus. It supports building codes in providing a standard of amenity and is not a health standard. Nevertheless the standard is the basis for smoke-free exemptions at restaurants in the ACT and a measure of success in reducing exposures to ETS has resulted.

Ventilation strategies to attain an "acceptable health risk" level indoors with smokers and nonsmokers co-located requires excessively high outdoor air flow rates costed at some $30,000 per smoker in capital cost alone. Thus an increase in general ventilation (or the use of air cleaners) is not cost effective.

A number of measures to reduce risk are feasible. These include separate smoking and non-smoking environments but this approach would certainly encounter difficulties of implementation in practice as it involves having dedicated smoking rooms which are separately ventilated by extraction of the room air.

If smoking is permitted indoors, this is the most effective method of preventing non-smokers from being exposed to ETS.

The only certain method of eliminating health risks from ETS in the workplace is by legislated 100% smoke-free premises. Even natural ventilation is then satisfactory.

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RECOMMENDATIONS

1. Where feasible, smoking indoors should be prohibited.

2. Where exemptions are judged necessary, these should be on the basis of complete physical separation of smokers and nonsmokers on different ventilation systems.

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SECTION 1 INTRODUCTION TO VENTILATION STANDARDS

1.1 Indoor Air Quality

Air conditioning systems are traditionally designed to control thermal parameters, provide ventilation and capture some airborne particles. The degree of particle arrestance depends largely on economic factors: high performance filters for operating theatres and computer centres, low performance filters for human comfort application. Occasionally high performance filters are installed for reasons of comfort in commercial buildings but this is generally for marketing purposes and the level of filtration may not be sustained after the building has been occupied.

In regard to ventilation, the present building regulations set by the Building Code of Australia (BCA) are based on the assumption that natural ventilation (openable windows) will be the first choice and minimum criteria for such natural ventilation are prescribed.

In the event of the criteria not being met, then mechanical ventilation or air-conditioning would be required as a permissible substitute.

Where mechanical ventilation is required compliance with AS 1668.2 is prescribed. The title of this Standard is "Mechanical ventilation for acceptable indoor air quality". AS 1668.2 is currently under revision.

The Standard has limitations in its scientific assumptions. For example, while reductions in outdoor air rate are permissible where the return air from the occupied space is filtered for removal of particulates (and gaseous contaminants), those reductions only reflect consensus criteria and guidance.

Because the Standard seeks to achieve a reasonable level of amenity only, many of its requirements are empirically based. "The extent to which these requirements (in the Standard) alleviate the risk arising from exposure to ETS has not been well examined and quantified" (NHMRC 1995).

1.2 Health and Comfort

Standards such as the American ASHRAE 62 (1989) and Australian AS 1668 Part 2 (1991) set out ventilation (outdoor air) rates that are acceptable for regulatory purposes. Typically, these standards are established from laboratory research into the ventilation required to ensure occupants are not exposed to an odorous environment. They are not health standards.

Historically, ASHRAE ventilation requirements per person reach a 'high' of 15 L/s per person around 1905. The rates were reduced to about 5 L/s resulting from the oil crisis in 1973 (and impact on heating oil consumption). In 1989 the rate was increased by ASHRAE to 10 L/s. Similarly outdoor rates set out in Australian Standard AS 1668.2 have also varied with each revision.

At the ventilation rates required by ASHRAE 62, 80% of visitors can be expected to express satisfaction with the indoor air quality, i.e. the standard is primarily based on perceptions of body odour.

Perhaps a good illustration of this basis for AS 1668.2 is the fact that ventilation rates for child-related occupancies are higher than for adults. This is because it was recognised in this Standard that children are more odorous than adults (refer Commentary on AS 1668.2, page 5).

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Australian Standard AS 1668.2 begins with a Scope clause:

"1.1 SCOPE. This Standard sets out requirements for air-handling systems which ventilate enclosures by mechanical means, where such systems are required by a Regulatory Authority. It sets minimum requirements for preventing an excess accumulation of airborne contaminants, or objectionable odours. These minima are based on needs for body odour control, air contaminant control, or carbon dioxide concentrations or a combination of any or all of these factors, depending on the particular situation. It does not prescribe other requirements associated with comfort, such as temperature, humidity, air movement or noise".

Adherence to the Standard does not eliminate the risk posed by any air pollutants that do not have a "nil-harm" threshold concentration as determined by a recognised health authority (Standards Australia personal communication).

1.3 Other Current Standards

The NKB (Nordic Committee on Building Regulations) guidelines recognise that the building surfaces themselves contribute to the contaminant load along with occupants and point sources. There is a basic ventilation value of 0.7 L/sm^2 for the building plus occupancy values. However, the total level must never be lower than 7 L/s per person in non-smoking spaces and 20 L/s per person where smoking is allowed (NKB 1991).

There is a DIN (Deutsches Institut fur Normung) standard on ventilation rates which is similar to the NKB standard (DIN 1992).

Because of different assumptions, the calculations for these standards may produce widely differing results. The most notable point of difference is whether the rates are listed per occupant or per unit floor area or surface area, or per combinations of these variables.

In an attempt to standardise these documents, or at least the methodology used in developing them, ISO recently appointed ASHRAE (with ANSI - the American National Standards Institute) as secretariat for the ISO technical committee work on ventilation. Along with this formal appointment goes the recognition that ASHRAE 62 represents the most widely used approach and so it may eventually be developed to become the basis for all these international standards.

Our own AS 1668.2 is generally consistent with the current (1989) ASHRAE 62 although some differences are significant. A revision to ASHRAE 62 has been drafted and is now available for public comment. AS 1668.2 is also currently undergoing review.

ASHRAE noted that environmental tobacco smoke (ETS) is considered to be carcinogenic by health authorities and decided that all outdoor air requirements in the revised Standard should be based on the assumption of no-smoking. There is an appendix to the Standard which discusses the issue of increased ventilation rates to achieve perceived acceptable IAQ in smoking premises but without necessarily providing health benefits. This appendix is, technically, not part of the Standard.

1.4 Governmental Approaches

Governments have generally left the matter of setting technical standards on ventilation to the appropriate standards-setting bodies and have then either adopted the standards in building codes or implemented broad policies. An example of the latter is the banning of smoking in federally controlled airports in Australia and the Australian Public Service, an initiative which has extended throughout all State and Territory government-run buildings and public transport vehicles as well as shopping malls and many other venues.

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A major investigation of the whole question of indoor air quality was carried out by the Ontario government.

1.5 The Ontario Government's Standards

Within the Ontario government, an Inter-Ministerial Committee on Indoor Air Quality was established in 1987 to develop protocols for investigating IAQ concerns and to recommend acceptable criteria for IAQ, including 'second hand' smoke exposure.

The research findings of this committee were presented in a paper to an ASHRAE conference (Rajhans, 1989). The committee did not set any guidelines for ETS but rather recommended to 'avoid any exposure to tobacco smoke'.

Other relevant extracts are:

> "Building inhabitants should be encouraged to adopt a non-smoking policy, both in view of the health implications for non-smokers and the fact that smoking is the largest preventable cause of death in Canada. This has been done for many Ontario Ministries and municipal by-laws have been enacted to this effect, e.g. Toronto. Designated non-smoking areas, without a separate ventilation system, are not effective in restricting exposure to second hand smoke. Separate ventilation systems for smoking areas have been recommended, but retrofitting an existing workplace with separate ventilation systems is often economically impractical."
>
> "The Committee recommends adoption of a non-smoking policy by Ontario Ministries due to the presence of several known or probable carcinogens as well as other toxins in 'mainstream' and 'sidestream' smoke. Until such time as the non-smoking policy is adopted, buildings should be provided with designated smoking areas with a separate exhaust and ventilation system.
>
> The Committee recommends that appropriate changes be made to the Ontario Building Code to reflect the findings of this report."

1.6 Further Comment

Ventilation standards have been developed worldwide to improve the indoor air quality in occupied buildings but they generally avoid specific discussion of the ETS issue; the increases in ventilation rates for occupancies permitting heavy smoking are aimed at controlling odour by ventilation dilution and do not adequately address health-related issues.

Ventilation standards are only one aspect of the overall problem of indoor air quality in general and ETS in particular. It should not be inferred that all problems are due to poor ventilation.

In regard to the Tobacco Institute's 1996 pamphlet on ventilation (Ventilation: the basic principles of air movement), this trivialises the seriousness of ETS by suggesting it is only a comfort-discomfort issue readily handled by judicious placement of smoking and non-smoking patrons and by use of low-cost ventilation apparatus such as window air conditioners and propeller exhaust fans. It is doubtful if the document would be taken seriously by restaurateurs other than in encouraging them to separate their customers into one of the two sections of the restaurant. Further, provision of makeup air from the smoking section to the kitchen is not acceptable.

A companion document produced in 1993 by Chelsea Group in the USA is entitled, "Ventilation for a quality dining experience". General comments on this document are in

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